economic circumstances, of their race, of any other circumstance.

Dr. Eliot is one of the truly great citizens of the United States who will inspire many generations to come. It is proper that the Academy, which shares her ideas and belief in mankind, should have honored her with the plaque on which are inscribed the following words:

In recognition of her outstanding contributions to the health and welfare of the children of the world.

I wish to thank for their warm support and helpful advice all the members of the Committee on Special Studies and to acknowledge especially the following members who served so ably as chairmen of conference panels and luncheon meetings: William W. Field, David Lyall, Samuel Standard, Byard Williams, and August H. Groeschel. My thanks, too, for his participation as a panel chairman, to George James, soon to assume his new responsibilities as dean of Mount Sinai Hospital's new medical school in New York. Leona Baumgartner, another former Commissioner of Health of the City of New York, is to be thanked for her gracious help to us in honoring Dr. Eliot.

Finally I wish to acknowledge the signal contribution to the success of the conference made by Harry Becker, who is Executive Secretary of the Academy's Committee on Special Studies. His vision in planning and implementing this project, and his consummate skill and energy in carrying it through, made it the best-attended, most noteworthy conference ever held by the Academy. His entire staff is to be commended, and special mention should be made of the invaluable assistance given by Marvin Lieberman, committee staff consultant in medical care, and by Antoinette A. Gattozzi, assistant to Mr. Becker and staff editor, who was responsible for most of the administrative arrangements for this conference and for the editorial work needed to prepare these papers for publication.

HAROLD JACOBZINER
Conference Chairman

PREFATORY REMARKS

Contained in this publication are the papers presented at The New York Academy of Medicine's 1965 Health Conference on the theme of "Closing the Gaps in the Availability and Accessibility of Health

Services." This theme was selected because today, as never before in our nation's history, there is general public and professional concern with the quality of life and the importance of health care in the fullest realization of our potentialities as human beings.

The Congress of the United States in 1965 has enacted legislation that represents one of the most truly significant changes in social policy for health care since the adoption of the Constitution. Over the past several decades, and increasingly in the past few years, our national social policy for health care has been changing. Recent legislative action is consistent with and confirms the general direction of the shifts in traditional public policy that have become increasingly more evident. The year 1965, however, will for many decades be looked upon as the point in time when major public changes in regard to the health services were formalized by congressional action. For many years to come all federal and state legislation involving the health services will reflect the changes in concepts of the role of government —and the commitment of government to the people it exists to serve— that were set forth in the laws enacted in the year 1965.

Implicit in our idea of a democratic society must be the assurance that all people have an equal opportunity to obtain a high quality of comprehensive health care. At the same time we recognize that presently available statistics and health-care studies show that a serious gap now exists between the state of health of significant numbers of people and the state of health that would be attainable if the best of present-day health-care knowledge were universally available and fully utilized by all people. If we are to attain this goal of equal access to a high quality of comprehensive health care, the governmental and the voluntary agencies must work together to abolish existing barriers to care. To do this we must first identify the reasons why any element of health service is not universally available to people at an acceptable level of quality. The second step is to take whatever actions are necessary to make needed services widely available. The task of closing these gaps in the availability and accessibility of health services, the theme of the papers in this publication, will be on national and community agendas for study and action for many years to come.

It is both legitimate and essential that governmental administrative agencies and legislative bodies become increasingly concerned that the goal of high-quality comprehensive health care for all our people be

reached to the fullest extent possible. Recently enacted federal and state health programs are going to bring into sharp focus the necessity of using all the nation's health-care resources in the most effective and economical manner possible, simultaneously taking whatever steps are necessary to strengthen and expand existing resources. At the same time there will be no relaxation of the growing concern that any health service provided to people, regardless of the source of financing, must be provided in a manner that will enhance individual dignity and, finally, that raising the quality of care will be a never-ending goal continuously being pushed forward as new knowledge and new technology become available.

These issues are no longer theoretical concepts set forth by technicians interested in social policy. The 10 per cent of the population 65 years and older who will soon be eligible for a universally available government-financed hospital insurance benefit will bring into public view all the policy issues implicit in the problem of closing the gaps in the availability and accessibility of health care. In this new age of electronic mechanisms, sophisticated computers nationally coordinated by the federal government will provide the Congress, the health professions, and the general public with a vast amount of information that will be the basis for making policy decisions on such questions as gaps, accessibility, quality, utilization, and costs of health care. Before the end of the 1960's the data produced by the federal government's information system, which will be recording for the first time an extensive amount of data on all aspects of the use of the health services by all persons 65 and over, may soon prove to be the single most important instrument shaping social policy formulations in the health-service sector of the economy.

The problems of gaps, accessibility, quality, utilization, and costs will dominate all health-program considerations for many years to come. Of equal importance, however, will be the attention that administrators of health programs strengthened or implemented by the action of society will be giving to procedures that recognize equal rights to dignity and self-dependency of all who seek or receive health care. Under the new program for persons 65 and over, for example, every person receiving hospital benefits has free choice of hospital and the right to a semiprivate room unless medical need indicates the need for a private room. The Congress has, in fact, passed legislation that elimi-

nates in the United States an indigent-aged category at the point an aged person enters the hospital of his choice for acute care. Because of this legislation an indigent person is only that individual needing more days of hospital care than are provided by law, or a person who cannot pay the deductible or coinsurance amount.

The hospital will be paid in accordance with the principle of "reasonable-cost" reimbursement just as it is paid by voluntary insurance organizations providing benefits to the gainfully employed. If the individual 65 and over elects to participate in the federal government's program of medical insurance he may have a personal physician of his own choice. The physician, similarly, is paid his reasonable and established fee.

Aged persons, even if receiving public assistance for income maintenance, no longer need to establish that they are indigent to receive tax-supported hospital services. Their accessibility to needed hospital care is without regard to economic status—medical need and medical need alone is the only criterion for admission to a semiprivate hospital bed. They have access to hospital care on the same basis as the most financially fortunate members of the community. The "means test," used for several centuries to determine the "right" to tax-financed hospital care, is no longer applicable to citizens of the United States aged 65 and older.

In the context of the subject matter of this collection of papers the congressional abolishment of the "means test" procedure for all persons 65 and over as a condition for receipt of hospital service has implications over the long term that cannot be overemphasized. It is a virtual certainty that before long the test of financial means to pay for health care from personal resources will cease to be a condition for receiving many types of tax-financed health care. A democratic society cannot for long favor one population group over other population groups.

About 50 per cent or more of all community tax-supported public hospital services are now being provided to persons 65 and older. Very shortly all community hospitals for indigent persons supported wholly or in large part by tax funds will need drastic revisions in current policy as a result of the new programs for the aged. The line of demarcation between the public and private hospital service has been, at least, partially erased. A big step has been taken toward the eventual establishment of a coordinated city-wide hospital system with a single basic

hospital service for all people in the community: medical need, not economic status, becoming the criterion for receiving needed hospital care. The many differentiations between private care on the one hand and tax-financed care for the so-called medically indigent on the other hand that now exist throughout the country will be modified in too many ways to warrant more than a speculative type of comment at this time. But change there will be, however slow and uneven, from hospital to hospital and from community to community.

With respect to the issues of gaps and accessibility the governmental insurance program for all the aged quite obviously raises the question of equal opportunity and equal treatment for other population groups. For how long can we use the instrument of government on behalf of our older citizens to arrange adequate financing of their health services —and to assure that initiative is taken to make available to all aged the combination of coordinated community services required for high-quality care—and not do as much for our children? From the point of view of society as a whole we could argue, perhaps, that we should have undertaken the development of organized programs for children at the neighborhood level before we mobilized funds and resources for health care of the aged.

Fortunately we have the economic capacity to develop and to provide the services needed by all our children, and, at the same time, to provide the hospital beds, skilled nursing facilities, and home care needed by all the aged in the community. Several of these papers point out existing gaps in programs for children. For the most part these gaps require an organized and coordinated effort on the part of governmental and voluntary groups to bring together the health team that is required for provision of prevention, diagnosis, treatment, and related services. Few urban problems seem to have a higher priority than that of assuring every child the very best in all the types of health care that scientific advances are making possible.

The next generation of children must face life's responsibilities with the right to a maximum of dignity and self-respect and with the knowledge that the society they are about to help govern exists for the purpose of assisting all people to attain the fullest measure of self-fulfillment. Poverty and the neglect of the health of children in disadvantaged families are closely interwoven. We need to know more about how the "means test" requirement for tax-supported health

services for children contributes to the family's feeling of being underprivileged and of having a second-class status in the community. To what extent are the "means test" requirement and charity-status medical services contributing to the complex of personality patterns in children from disadvantaged families? Are they helping to breed even another generation of persons destined to live in pockets of poverty?

There are other population groups to which the principles of social policy now adopted for persons 65 and over probably should apply. Persons who because of chronic illness are not members of the labor force are one illustration. The unemployed, the family without a wage earner, the physically handicapped, the migrant worker, and the underemployed are other groups, to name a few examples. Shortly we shall examine all disadvantaged groups in the frame of reference of the public policy decisions on presumptive need made in relation to the health services for the aged.

This conference did not investigate the problems associated with the gainfully employed and the financing of their health-care needs. We have developed a pattern of financing under which the gainfully employed will come under the voluntary insurance mechanisms—and under which other groups will be assisted in various ways by government-initiated programs. One of the conference discussants has pointed out that the voluntary insurance mechanisms must be reworked if they are to meet today's problems in providing a method for financing needed health care for gainfully employed persons. Now that the aged are no longer a burden on voluntary health insurance agencies, and now that hospitals will be paid their reasonable cost for all indigent care, where federal funds are involved, it is time to rethink and redesign many facets of existing voluntary health insurance plans.

Not enough has been said about the level and scope of benefits to be expected from voluntary health insurance financing, nor have we said enough about the cost of these benefits. The aged under the governmental insurance program now have a higher benefit standard than a very large segment of the gainfully employed population—at a maximum current cost to the aged of $3 a month. It will be difficult to accept the situation where the man aged 65 or more, who is working on the same bench with another man under the age of 65, will have higher health-care benefits at a lower cost to him or his employer than his younger associate covered by the employer or the employer-union

negotiated program. Persons who are self-employed and are covered under nongroup contracts will soon feel they have every right to expect protection at least equal to that provided to older persons and at a cost within their financial reach. Domestics and farm workers also will want no less in protection.

Voluntary health insurance must now come to grips with a large range of unsolved problems as we move into the filling of the gaps in health services and the meeting of problems of universal accessibility. The small employer, often operating a marginal business enterprise and employing labor that is not infrequently also marginal, is in many cases already having a problem meeting the cost of voluntary health insurance for benefits now below the community standards. A large and important new disadvantaged group consists of small employers trying to meet their competitive price problems by employing family members and marginal employees at less than prevailing wage rates. The complex question of some form of tax subsidy for voluntary health insurance to reduce as well as to distribute premium costs more evenly over the entire community is a problem a number of state legislatures already have under discussion. The growing interdependency of public and private financing and the relationship between the availability of a high quality of community health service and adequate financing will intensify concern that the voluntary insurance agency assume full responsibility for public accountability in the expenditure of funds and in administrative policies. These are problems that in one form or another will be receiving increased public attention.

This conference, in various papers and discussions, has pointed out that as a result of the new health legislation government agencies will be increasingly concerned with the following functions: 1) establishment of priorities for new as well as existing health programs; 2) allocation of funds needed to achieve these priorities; 3) implementation of such measures as are required to assure universal access to health care; and 4) introduction of such effective controls as may be needed to assure a high quality of care, economically provided.

At the same time that the above functions were recognized as the responsibility of governmental agencies, conference discussions also pointed up the need for tax-supported efforts to encourage various demonstration and research efforts directed specifically to understanding methods for strengthening the effectiveness and efficiency of health-

care programs. The paper by James T. Howell, director of the Henry Ford Hospital in Detroit, Mich., reports on one nationally significant demonstration and research efforts directed specifically to understand-Hospital experience to be made publicly available for many years. This and many other program innovations throughout the country are sure to be under close examination during the next few years.

E. Richard Weinerman, in the opening keynote presentation, sets forth a number of basic considerations that must be taken into account in planning for tomorrow's health care. The validity of many of his "anchor points" is made evident by the number of times the various papers presented to the conference develop the same idea in various ways. He gives emphasis to the fact that: "The 'fire-department' concept of the physician on the ready to rush out to extinguish the conflagration of sudden illness has long since been demolished by the predominance of chronic over acute disease." He points out in a variety of ways that the community medical-care system must reach out into the healthy population. This calls for special methods of screening and full access to the indicated diagnostic and therapeutic follow-up service.

In a nine-point "Policy Statement on the Role of Government Tax Funds in Problems of Health Care" adopted on May 26, 1965, by the Trustees and Council of The New York Academy of Medicine, the following conclusion was a part of the total document:

> The availability of health services, as a matter of right, should be based on health need alone, not on a test of ability to pay. The attainment of this goal requires the broadest possible participation in the systems of financing health services, if individual dignity and self-dependency are to be enhanced.

The underlying concept of this policy statement is evident in a number of the papers. Dr. Weinerman develops this point by such statements as: ". . . the means test and the economic deterrent to early use of service is inconsistent with either good medical care or acceptable democratic practice." Claire F. Ryder outlines the gaps in services with emphasis on chronic illness and discusses the need for more and higher-quality skilled nursing service. She adds that these services must be available to all in the community regardless of ability to pay. In a somewhat different frame of reference, Robert Morris points out that today's gaps in health services require, in the future, that "a disproportionate share of our growth needs to be directed to certain kinds of

health needs that cannot be provided solely on a competitive market basis." He concludes that: "Expenditures for health care, if the needed expansion of services is to be realized, require national planning and national allocation of resources."

Samuel Mencher has this to say in his paper: "The responsibility for medical care has clearly shifted from the public health model. This is indicated not only by the societal trends already noted, but by trends within the practice of medicine that have made medicine a large-scale industry requiring financing and organization on a scale that only government can undertake effectively. The problem then, at this time, is not the breadth of government responsibility for medical care, but rather the most effective fashion of carrying out the responsibility."

The conference raised more questions than it answered. This was anticipated. The underlying purpose of such a conference is to provide a forum for the exchange of ideas and to encourage creative and imaginative discussion. We shall always want to examine the quality of human experience and to find ways to enhance individual dignity and well-being. The Rev. Dr. David H. C. Read, however, says: "There is a common assumption in our pragmatic society that we know what we are after and the discussion, therefore, is to be about the means of getting there. And yet from time to time I have an uneasy feeling that, as a community of people in the world today, we are not too sure of what we are after, and that in our tremendous preoccupation with means, we have lost sight altogether of the ends." He adds, ". . . we have built up the most fantastic means of doing things, and we have tremendous discussions about how they should be done. But not too often do we start asking the fundamental question—What is it all for? . . . What are we after? . . . What kind of human being do we have in mind?"

Although we did not, nor shall we ever, resolve these issues raised by Dr. Read, the conference and recent legislative events indicate that, as far as health is concerned, we are beginning to answer his questions more decisively than was true a few years ago. The existence of the gaps in services is recognized. The focus today is not on the right to equal access but is, rather, on how to assure this right for all of our people. This accounts for the attention given to the role of government in the establishment of priorities and in taking such action as may be needed to allocate funds in a manner that makes equal access and

availability an attainable reality.

These comments are not intended as a summary of conference highlights. They are, rather, random observations to help illustrate that never before, as a nation and as professionals concerned with health care, have we agreed so commonly that there are gaps and barriers to the availability and accessibility of high-quality comprehensive health care. Not only is a general consensus developing that supports these central ideas, there is also ample evidence that many historical precedents and conceptions are being questioned.

Social policy relating to the health services is changing. Legislation is being enacted that establishes new public policy bench marks. The voluntary and governmental sectors are tearing down walls of separation constructed long before the early settlers moved into the new world to build a new society.

This conference and its collection of published papers are not intended to put together in a single package the model for tomorrow. The hope, rather, is that the reader and student will find in them the tools needed to help understand some of the forces at work that are demanding that we rethink where we are, and where we want to go from here, in making health care as fully as possible an instrument for a greater measure of self-fulfillment for all our people.

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