HEALTH PERSPECTIVES

A NON-PROFIT TAX EXEMPT ORGANIZATION

VOL. IV, No. 3 PUBLISHED BY THE CONSUMER COMMISSION ON THE ACCREDITATION OF HEALTH SERVICES, INC. May-June 1977

Pub. 10/77

NATIONAL HEALTH SERVICE III

NHS I-II SUMMARY

"National Health Service I" (HEALTH PERSPECTIVES Vol. IV, No. 1, Jan.-Feb. 1977) analyzed several weaknesses of the American health care delivery system. The American Public Health Association, the Consumer Commission and a growing number of professional and consumer groups and individuals believe that a national health service, composed of institutions owned by government, controlled by consumers and staffed by professional and non-professional salaried health care employees is the most economic way to provide accessible, quality care to everyone.

"National Health Service II" (HEALTH PERSPECTIVES Vol. IV, No. 2, Mar.-Apr. 1977) concluded that a transition step to and a continuing policy of a national health service must be the granting of the privilege of participation in government funded programs only to those health providers (institutions and individual professionals) whose services are deemed necessary to provide quality care for a specific geographic region. The benefit of this policy would be to more closely relate the distribution of health care resources to the needs of the population. As a step toward a publicly controlled national health service, "National Health Service II" advocated that all hospitals be required as a condition of participation in any publicly funded health program to reconstitute their governing bodies to include a non-provider majority consisting of consumers representing the social, economic and racial components of the community; representatives of the institution's employees; and public officials. NHS II argued that facilities needed for a national health service which are now privately owned and operated for profit should be purchased at fair market prices under the principle of eminent domain.

Moreover, the March-April 1977 issue recommended strengthening the institutional review responsibilities and mechanisms of the Health Systems Agencies (HSA's) created by PL 93-641. By requiring that HSA's be public (rather than private non-profit) organizations, and expanding their authority to include the review and approval of existing institutions, facilities and services, the nationwide network of HSA's would constitute an improved framework for the regionalization of health services.

THIS ISSUE: REGIONALIZATION

This issue explores the efforts of America to plan for efficient and effective health services. It will briefly examine the history and results of similar efforts in Great Britain and Sweden and will look at the reasons for, steps toward, and organization of a regionalized health care system.

The need for and advantages of a publicly controlled and operated national health service have been discussed in previous issues of HEALTH PERSPECTIVES—NHS I and NHS II. Additionally, the history of the United States which shows that an uncontrolled marketplace in health delivery has produced a costly and inequitable system which now necessitates fundamental changes was reviewed. An understanding of this need to change is reflected in current improvements in the health planning process. Nevertheless, the question remains—can planning really effect the needed changes?

An unregulated market needs no planners; supply and demand are controlled by marketplace forces. However, in the health care field where marketplace forces operate poorly, chaos and monopolistic practices have been the direct result. This issue of HEALTH PERSPECTIVES will discuss the organization believed to be the most rational and equitable for the delivery of personal health services, medical education and research—regionalization. It represents a viable alternative to the current uncoordinated, inefficient and inequitable system.

Regionalization requires systematic organization and focus on population needs; it requires that government, representing and assisted by citizens, own and operate the health system. *In other words, to reap the full advantages of regionalization a national health service is a must.*

BRIEFLY—THE ADVANTAGES

A regionalized system economically integrates preventive, ambulatory, emergency, inpatient, home care, long-term care and related supporting services. Regionalized health care systems generate more appropriate patient utilization of services; improve patient care; distribute more rationally facilities and personnel; and include a responsive system of medical education. A regionalized national health service obviates the need to devise and administer narrowly focused programs whose potential users are selected by economic, geographic, age or disease category criteria and whose funding and administration emanates from any or all levels of government. With all health care facilities publicly owned or controlled, consumers are effectively integrated into the planning, development and operation of all health services. Regional and national health priorities are developed and integrated within one system and ultimately under one governmental agency which has the authority and responsibility to meet its obligations.

CARE LEVEL EQUALS NEED

Basic to the concept of regionalized health services is the development of a network of interrelated health facilities providing primary, secondary and tertiary levels of care. These levels are differentiated by types of health problems treated, incidence of these problems in the population, intensity of technology and relationship to medical education and research. Additionally, a regionalized system places greater emphasis on identification and prevention of illness and accidents. Basically, its focus is the patient, not the provider. Three levels of care are usually identified:

(1) Primary care addresses all common health problems

TABLE I

A REGIONALIZED SYSTEM FOR THE DELIVERY OF PERSONAL HEALTH CARE

Level of Care	Administrative Unit	Facility	Population Served	Major Functions	Referral Patterns	Consultant Services
Tertiary	Region	Medical Center	1 million optimal minimum	Highly specialized care, Education Research	Internal and from other levels	Provides to other levels
Secondary	District	Community hospital	50,000 optimal minimum	Specialized inpatient and limited ambulatory care for acute patients	To tertiary care facility	From tertiary care personnel
Primary	Area	Neighborhood health center Workplace clinic Nursing home	25,000 optimal minimum	Ambulatory and routine care	To secondary care facility	From other levels

and includes the prevention and detection of disease. Problems such as minor accidents, gastro-intestinal disturbances, arthritis, asthma, flu, etc. which affect large numbers of people are treated at this level. Multiple mechanisms and sites, such as community health centers and workplace clinics, are appropriate and necessary for the provision of primary non-emergency care services in a prompt and equitable manner. The regional model envisions primary care provider groups operating in the area around a community hospital to which patients requiring secondary care are referred.

(2) Secondary care is available to handle less common health problems such as industrial, agricultural and traffic accidents, burns, fractures, tumors, certain cardiac disorders, etc. which are generally less likely to occur to any one individual. These health problems require specialized care that can only be provided efficiently and with acceptable quality at community hospitals. A minimum population of 50,000 is needed to generate enough demand to justify these services. However secondary care facilities are more efficient serving a population of approximately 200,000. In a regionalized system several community hospitals coordinate with one tertiary care center.

(3) Tertiary care describes highly specialized, technologically intensive services, such as open heart and brain surgery and those necessary to handle congenital abnormalities, malignant neoplasms, endocrine disorders, acute poisonings, etc. which have a very low probability of being experienced by any one individual but whose occurrence is relatively predictable in populations over 500,000. Tertiary care is provided in large health centers which are often affiliated with universities or medical schools. To provide services on a cost and quality effective basis a tertiary care center should serve one to several million people.

The population of a defined geographic region has specific health service requirements and the amount of care required at each level can be predicted and provided within a regionalized system. Thus, population need is the basis for the distribution of health care resources.

A CHANGED ROLE FOR THE MEDICAL SCHOOL

The role of the medical school in the delivery of services is clearly defined in a regionalized system with the benefits of recent advances and specialty knowledge equitably distributed. Most tertiary care centers will be affiliated with a medical school and an important part of the responsibilities of the faculty and students of such institutions will be to provide consultant and educative services to medical personnel on the secondary and primary levels of care. Both through actually travelling out to these other facilities to lend technical assistance and conduct continuing education workshops and through making a portion of their in-house time available to analyze cases on which their opinion has been solicited, the benefits of specialty knowledge will be brought to bear on all cases where it is required. Through contact with consultants, special education programs and rotation to other levels of care the system will provide for the ongoing education of all health workers.

In order to achieve the benefits of regionalization, there must be a well-defined relationship among the three levels of health care which includes patient referral patterns, an organized flow of patient data, special consultant services and rotation of providers through the system to assure proper continuing education and communication. The medical school affiliated with a tertiary care center stands at the apex of the regionalized hierarchy. It is from here that assistance and education flows and to here that patients requiring super-specialized care are referred. (These relationships are summed up in Table I.)

PROGRESS SHORT

The U.S. health care delivery system does not coordinate the availability and utilization of services and facilities or medical education and research with population needs; does not control costs, quality or appropriateness of services; does not respond to consumer demands; and does not moderate the influence of self-interest groups. (See Box "Fragmentation: All Around Us".) Although the advantages of a publicly controlled regionalized health care delivery system are recognized throughout the world and these systems have been created in both industrialized and underdeveloped countries, neither regionalization nor public control has been seriously tried in the United States.

REPORTS LONGER—DAWSON REPORT

The Consultative Council of Medical and Allied Services issued its report (the Dawson Report) to the British Parliament in 1920 in which the first twentieth-century, western regional health care system was proposed. Its interrelated three-tiered system consisting of primary health centers, larger secondary centers and more specialized medical centers has become the most widely accepted format for the design of regional medical delivery.

The Council's plan emphasized the integration of preventive and curative medicine with services coordinated through a network of clinics and hospitals. It included the provision of dental care at the primary level and transportation service from the patient's home to the clinic or hospital and between facilities. Community health centers, home care services and group practices were all a part of this health delivery system.

The Dawson Report recommended that a single health agency be responsible for coordinating services in each region. It suggested that this body be either a statutory committee of an existing local authority or an ad hoc independent body. The Report suggested that this regional authority be composed of 60% consumers elected by popular vote and 40% providers nominated by a local medical advisory committee.

The Dawson Report recognized the regionalization of medical care delivery as a way to match the health needs of the population with a nation's health resources. Its most significant contribution was the concept of a health service area in which primary, secondary and tertiary levels of care are coordinated to most effectively deliver preventive, acute, emergency and rehabilitative services.

REPORTS—CCMC

The Committee on the Costs of Medical Care (CCMC) was established in 1927 in Washington, D.C. It was "organized to study the economic aspects of the prevention and care of sickness, including the adequacy, availability, and compensation of the persons and agencies concerned." The final report of the CCMC was published in the United States in 1932 and is considered a landmark document. It presented a plan containing the major elements of a regionalized system for the delivery of personal health services and emphasized the establishment of hospital-based group medical practice which was thought to be the most effective way of providing integrated preventive and curative services on a continuing basis in the patient's home, the doctor's office and in the hospital. An additional key aspect to the CCMC plan was that medical centers were to be governed by a board broadly representative of the community served.

In 1932 the CCMC report recognized the importance of regional planning and community representation on hospital boards. The report also suggested that planning and coordination be the responsibility of a local agency containing consumer representatives. A state level agency or board would be vested with ultimate authority over the various localities.

REPORT TO LAW

Since the end of World War II, the federal government has assumed a greater role in financing health services. The government has also begun to seek control over costs and quality. However the major premise of most legislation has been that health providers would voluntarily monitor themselves and correct major deficiencies. But volunteerism has not worked and it has become apparent that the needed changes must be mandated by law and enforced by government.

THE HOSPITAL SURVEY AND CONSTRUCTION ACT, PL 79-725 (THE HILL-BURTON ACT)

The legislative history of regionalization in the United States began with the Hill-Burton Act of 1946. The Act's major purpose was to support state surveys and plans concerning the need for hospital facilities and to provide matching funds to construct facilities deemed necessary. Although there was some discussion of a four-tiered regional plan during Senate hearings, the legislation did little to advance a regionalized health system. In 1964 amendments to the Hill-Burton Act provided grant money for the establishment of areawide health facility planning agencies. However, the lack of regulatory power and the narrowness of the scope of concern of these agencies were major defects in the legislation and neither planned, coordinated services nor regionalized delivery systems materialized; the Act resulted in widespread uncoordinated construction of facilities. Instead of government funds being used to rationalize the health industry, it was used to encourage rampant hospital construction in the private sector with the additional repercussion of fostering growth of a strongly independent and self-interested hospital industry. All subsequent attempts to introduce effective health planning legislation have been fought by this powerful lobby.

HEART DISEASE, CANCER AND STROKE AMENDMENTS, PL 89-239

PL 89-239 (1965) authorized the establishment of Regional Medical Programs (RMP's) to promote regional cooperation among hospitals, medical schools and research centers in order to facilitate access to innovative techniques of diagnosis and treatment of heart disease, stroke and cancer. This law emerged after the release of a Presidential Commission's report recommending a national regional system to facilitate the availability of diagnostic and treatment advances to those suffering from these categories of disease. However, the legislation that was finally adopted fundamentally modified the concept of a regionalized system to accommodate the objections of physicians, hospitals, and medical schools. Because of strong provider reaction to the original regionalization concept explicit implementation plans were never formulated. Moreover, the RMP's had no authority to require provider adherence to established plan guidelines.

COMPREHENSIVE HEALTH PLANNING ACT, PL 89-749 (CHPA)

The planning agencies created by the Comprehensive Health Planning Act of 1966 replaced those created by the 1964 Hill-Burton amendments. The new planning agencies were created to handle planning functions for institutions at state and areawide levels. However, as with the Hill-Burton agencies and RMP's, these new agencies were given no power to implement their plans. And, although subsequent legislation granted them the right to "review and comment" on plans submitted to them for expansion, contraction or remodeling of health institutions, without the ability to enforce their decisions or to implement their own plans, these agencies were ineffective. CHPA was a planning law; however, neither in the legislation nor in the history of the program can any indication be found that regionalizing health care delivery was one of its objectives.

THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974, PL 93-641

This Act is currently being implemented and replaces the three programs previously discussed. It sets up a three-tiered system of planning agencies—federal, state and areawide—each of which is required to develop long and short range plans. Health Systems Agencies (HSA's)—the areawide agencies—have the power to approve and disapprove some federal grants and contracts and to evaluate and recommend action on proposals to construct or modernize health care institutions in their area. The State Health Planning Councils (SHCC's) are responsible to administer Section 1122 of the Social Security Act (certificate of need) laws. (For an analysis of certificate need and health planning see HEALTH PERSPECTIVES "National Health Service II," March-April 1977, Vol. IV, No. 2.) Once again regionalization is not a specific goal of this planning legislation. Additionally, the agencies created by this law have not been given the specific authority to discontinue services deemed unnecessary nor have they been authorized to use reimbursement rates or formulae or to develop other provider payment mechanisms with which to compel compliance with local health plans. (For an analysis of reimbursement and health planning see HEALTH PERSPECTIVES "Health Planning and Reimbursement," July-August 1976, Vol. III, No. 4.)

DESTINED TO FAIL

Up to now all attempts to plan for or regionalize health services in the United States have been destined to fail. The result of depending on voluntary self-regulation has been burgeoning unplanned hospital construction, funneling public money into private medical schools through subsidization of medical research and regional plans being drawn and shelved. The history of American efforts to rationalize the health care sector has been dismal. Fragmentation of responsibility and lack of public authority has and continues to allow inappropriate utilization; the continuance of substandard and unnecessary beds, services, and institutions; unwarranted construction; cost escalation; and, mitigates against the achievement of planning goals.

OTHER COUNTRIES

Regionalized, public health care systems are considered the most efficient, effective way to deliver medical and preventive care. When designing a health care system for devel-

(continued on page 6)

FRAGMENTATION:

HEW SECRETARY SAYS:

Joseph Califano, Jr., the current Secretary of the Department of Health, Education, and Welfare (HEW) recently listed a few of the current problems in the American health care system:

First: Our health resources, abundant as they are, are not well-distributed, either economically or equitably...

Second, not only are our health care resources poorly distributed, but they are often not organized as efficiently as they might be...

Third, with little incentive to be cost-effective in the use of skills and resources, it is no wonder that our present health-care system emphasizes treatment of illness rather than prevention of illness...

Fourth, our system of health insurance in America is an expensive and inequitable crazy quilt...

But the overarching problem of the health care industry in America is the problem of runaway costs.

To these we add the lack of adequate quality controls; lack of adequate accountability mechanisms; lack of public information; the organization of health delivery to suit medical students and practitioners rather than consumers and patients; and the cooptation of regulatory and planning agencies by professional groups working in behalf of their self interest.

IN THE PRIVATE SECTOR

In the United States there are 6,600 general hospitals, 22,000 nursing care and related homes, thousands of clinical laboratories, thousands of clinics, hundreds of group practices, 345,000 physicians, 274,000 dentists, and 4.4 million health workers. In each metropolitan area there are literally dozens, if not hundreds, of institutions and thousands of practitioners, each competing for the individual patient. However, there is almost no coordination between health care facilities, and there are very few controls on individual providers.

140 million Americans are completely dependent on private financing and services for their health care. Additionally most of those who depend on public monies receive their care in private not-for-profit or proprietary institutions and from private practitioners.

When seeking health care in the private sector consumers face a formidable array of choices about which they have limited ability to make informed decisions. (Where do I get a doctor? What is the doctor's training? Where do I get care? How are hospitals rated?)

Individualism and autonomy have totally dominated the picture leading to the proliferation of isolated private doctor offices, clinics, group practices, foundations, hospitals, nursing homes, research oriented specialized services, and a geographical and specialty maldistribution of practitioners and services. The effects of private insurance and the complex network of public programs reinforce fragmented services and contribute to limited access, restricted benefits and varying qualities of care.

In this non-system a person can enter anywhere from the office of a private practitioner whose training may be 30 years out-of-date, to an emergency room staffed by moonlighting medical residents, to the out-patient department of a super-specialized teaching medical center.

A person can by ignorance or affluence enter the health care system on the secondary or tertiary level when they actually need a primary care physician. Conversely, a person needing secondary or tertiary care might enter the system on the primary level and never be referred up to a more appropriate level of care. It often makes no difference what the diagnosed or suspected illness may be. In virtual ignorance the consumer chooses an entry place and, often remains there. The primary care physician, with little incentive to refer to the appropriate specialist, may treat a person beyond their training or competence. A specialist will more often refer a patient to another specialist rather than a general practitioner. Luck, word of mouth, referrals, whether you have a doctor, and where the doctor is affiliated determines where treatment takes place. It is no wonder that with all these possibilities most people receive inadequate and discontinuous care and some are unable to obtain any care at all.

AND IN THE PUBLIC SECTOR

Government has superimposed on this non-system its own complex system of categorical grants subsidizing specific populations' receiving care in the private sector. There is little direct provision of service by government and government grant and subsidy programs have not been concerned with increasing the appropriateness of care received, reducing confusion or increasing the knowledge of consumers seeking care in the private sector.

The incredible administrative and jurisdictional fragmentation of public programs and agencies makes it impossible for people to get comprehensive, coordinated services. Several programs, such as mental health, are designed for selected segments of the population and fall under the jurisdiction of the states. Other programs are targeted at people having specific diseases or ages who live in a specified catchment area or region of the country. Responsibility for these programs may be lodged on any level or dispersed among several levels of government. Responsibility for planning, financing, construction and regulation of health care facilities are also lodged in various levels of government with little coordination between or among them. As a result, we have incomplete and fragmented services which do not meet the health care needs of people and a plethora of public programs and agencies existing at all levels of government, and crossing political, economic, social, jurisdictional and geographical lines. Each segment is separately supported, funded and administered by various levels and agencies of government. This confusion of responsibility and authority inhibits the rational distribution of health care services. It makes it difficult for people to get comprehensive, integrated treatment or preventive care. The tangled net of these different programs creates duplications while leaving enormous gaps in services.

SPECIFICALLY AT THE STATE LEVEL

It is primarily at the state level of government that policy implementation takes place. State governments control, or have the potential to control, the distribution of most of the public's health care dollars. Thus it is at the state level that fragmented responsibility is most severely felt and wheel-and-deal politicking to divvy up the health-wealth is at its worst. At this level also, the evaluation and decision-making processes are almost completely impervious to effective consumer input.

Responsibility for the regulation of both the cost and quality of medical care is by and large lodged in the state governments. By law, state health agencies are granted comprehensive powers to ensure the health of citizens, including authority to regulate both quality and costs of medical care. The result has been a dismal failure.

State health agencies have consistently avoided the

ALL AROUND US!

responsibility of exercising their mandate to protect the public's health. (See HEALTH PERSPECTIVES, "National Health Service II", Vol. IV, No. 2 March-April 1977 for a summary of the Moreland Act Commission Report on Nursing Home Regulation with a detailed analysis of this type of dereliction in New York.) State health departments frequently dissipate their regulatory powers by delegating them to non-state bodies such as state-level provider-dominated committees. Often state departments of health are controlled by a Board of Health which is often provider-controlled—only 12% of the 433 seats on state boards of health are held by consumers. Moreover, a great deal of state regulatory power is dispersed among many departments rather than being concentrated in one.

What regulatory power remains for the state health agency is not a coherent power; rather it is purposely shattered among the various bureaus, divisions, departments, etc., of several agencies. (In New York State, 41 subdivisions of the State Health Department have regulatory responsibility!) Even if the states did try to perform effective regulation, there is further fragmentation of regulatory authority among a multitude of federal, local, quasi-public and voluntary bodies. The product of this potpourri is at best ineffective duplication and at worst mutual cancellation. Unfortunately cancellation is the most likely outcome. (For at least six years 90% of New York City's voluntary hospitals have not undergone Article 28 surveys as required by New York State health law!)

Priorities can be deduced by evaluating the amounts of money spent on selected activities. For instance, the amount spent nationwide on direct regulation of facilities, services, and manpower by state health agencies is insignificant. In 1974, only $62.1 million—1.3% of the total state health agency expenditures of $4.87 billion—was used for regulation of health providers. Between 1974 and 1975 the percent that state health agencies spent for regulation of services and facilities dropped by over 7%, while funds for regulation of manpower decreased by 25%. During this time, the numbers of state health departments performing various regulatory activities also decreased.

The recent history of health care shows that control of financing brings with it control of planning and regulation. As medicine has become a more and more profitable business, the provider-merchants have taken—or been given—legislated control of many aspects of their industry, especially regulation. Enmeshed in appointive bureaucracy, the state health agencies are easy targets for rampant provider influence and political pressures.

Power is also measured in the ability to control dollars, and although there has been a recent movement among the states to legislate hospital rate review powers for themselves, control over costs is an area where state health agencies have minimal force or effect. Medicaid pumps billions of dollars annually into the American health care system. Virtually all of the states and territories participate in the Medicaid program and, although Medicaid's purpose is to pay for medical services, in only ten of the participating states and territories is the power to approve or disapprove disbursement and the responsibility to do the disbursing of Medicaid funds lodged in a health agency. Only *one* of these ten state health agencies, the Virgin Islands, has the combined authority to set rates of payment and approve or disapprove payments and only three can demand a fiscal audit of those they pay. Fiscal starvation, unaccountability and organizational fragmentation have caused the states to be little more than open faucets for public dollars.

Unfortunately, regulation is a much talked about but infrequently practiced activity. What little of it is being done is directly or indirectly (advisory committees, staff services, etc.) controlled by the health industry itself.

OVER ALL

The United States has ample resources to provide comprehensive health services for the entire population, but the systems of planning, organizing, providing, financing and regulating health services have failed to provide the means for achieving even the most basic objectives of a comprehensive national health service. What has passed for government health policy today reflects the longstanding division of powers among several levels of government; the historical dependence of government on voluntary associations and individual effort; and, sometimes, just a simple faith that since no major catastrophes have come to light everything will work out for the best. The effects of fragmentation are pervasive: unequal access to care and gaps and inequities in services are rampant; there is virtually no preventive care; discontinuous and sometimes inappropriate care are not unusual; the system does not respond to the changing needs of consumers in a timely manner.

In addition, the reliance on multiple sources of financing results in varying amounts of co-insurance, deductibles, benefit periods which require multiple billing, complex administration, and contributions from people often unable to pay—all to pay for the care of one person or family or to support a single service!

Obviously, not all of the limitations and defects in the current United States system of health care services can be attributed to uncoordinated purposes and multiple programs, but fragmentation does contribute to these defects and continues to block their correction. To a major extent this fragmentation is a reflection of the larger problem of government reliance on the private sector to provide health care services and delegation of its responsibility to protect the public's health to the institutions and providers who are in a position to abuse it.

This is the third in a series of issues in which the Consumer Commission is examining the need for a national health service capable of providing equitable and quality health/medical care services to all the people in the United States without regard to their ability to pay. The Consumer Commission is interested in your ideas and opinions on this subject, and shall consider the publication of supporting or opposing views in future issues. Articles forwarded to the Consumer Commission for consideration should be between 500-1000 words.

(continued from page 3)
oping nations, public health experts almost invariably design a regionalized system. In countries where the government owns all resources and economies are planned—the Soviet Union, Eastern Europe, Cuba, etc.—regionalized delivery of health care within a national health service is virtually universal. In the United States, however, there has been no one locus of decision-making power and the health care system has evolved incrementally over hundreds of years. Special established interests have acquired considerable power and work against change; their position is reinforced by political, economic and sociological traditions which consider private control of the means and distribution of goods and services the ideal. Yet, we know that national health services exist in Western industrialized countries. Great Britain and Sweden are examples of the history of countries struggling to introduce changes in traditional systems against the will of established interest groups. In the latter, the effects of centuries of public ownership of hospitals and the natural evolution into a national health service are best seen.

BRITAIN'S NHS

In England the idea of medical care as a basic right was institutionalized when the National Health Insurance Act was passed in 1911. Over the next 35 years, the income threshold for health insurance increased until the National Health Service was established in July 1948. From 1948-1974 the structure of the NHS remained as it was originally established. Its foremost achievement was the elimination of financial barriers to health care. However, the system was fragmented with its administration divided into three separate sectors: hospital and specialist services; general practitioner services; and local authority public health services. Despite problems of coordinating these three sectors significant improvements were effected: financial barriers to quality medical care were eliminated; comprehensive coverage became universal; utilization rates and costs have not produced the feared "runaway" situation; and England ranks higher than the United States in most health care indicators. (See Table II "International Health Care Indicators".) In 1970 per capita expenditure on personal health care was $125 in England or 38.5% of the $325 per capita cost in the U.S. In 1974 when 7.7% of the United States' Gross National Product (GNP) was spent on health services, Britain allocated only 5.5%. Surgery rates in England are approximately one-half that of the U.S. The infant mortality rate of 16.9 per 1000 live babies and the maternal mortality rate of 11.2 per 100,000 live births rank higher in international comparisons than America's. Fifteen years after the establishment of the British National Health Service Britain's "undoctored areas" had decreased from 50% to 20%.

Still the British system was plagued with contesting powerful interest groups, overlapping areas of responsibility, lack of coordination, fragmentation and redundancy in services and poor health services planning and policy-making. In 1974, the British National Health Service was reorganized to increase regionalization and to integrate the administration of services. Hospitals, ambulatory service, and public health organizations are now united under the Department of Health and Social Security and the country has been divided into regional, district and area authorities. The reorganization has weakened the power of each interest group, thus strengthening the National Health Service and its ability to improve services. It is expected that this reorganization will enable the health service to have a broad planning perspective and the ability to produce specific programs for local needs.

In Britain a national health service has been a reality for almost 30 years. During that time the availability (better geographic distribution, lack of financial barriers and increased comprehensiveness) and quality of health care has markedly improved.

AND IN SWEDEN

Health care is a basic right in Sweden. Hospitals have been owned by the government for at least the last 200 years. Since 1862 Sweden has been divided into 23 County and 3 City Councils which have the responsibility to provide medical care to temporary and permanent county residents. These Councils exercise a significant amount of independent authority in administering health care in their areas. In fact, health care is so important to the Swedes that 70-80% of their County Councils' budget is spent on health related matters.

Seventy-five percent of the cost of medical care is paid for by county income taxes levied on employers and the self-employed. Eighty percent of Swedish doctors are employed by the local county. At the national level a political Ministry of Health and Social Affairs and professional National Board of Health and Welfare oversee construction contracts, research, education, licensure and planning.

Sweden's health care system comes closer than Britain's to the model regionalized system. The country is divided into seven medical care regions which have an average of slightly over a million inhabitants. Each region has a tertiary care medical center, six of which are associated with medical schools and all of which play an important part in medical research. There is approximately one general hospital (a secondary care center) in each county although some counties have several centers. Outpatient care is organized in primary care districts each of which serve from 10,000-50,000 people. There is usually one or more health center and one or more nursing home in each primary care district. Each region is essentially a self-supporting health district. Each county develops its own bed and personnel to population ratios with ranges and limits, and determines other service allocations according to its demographic statistics, prevalent diseases and selected socio-economic factors.

Financial barriers to health care have been virtually eliminated in Sweden. There are token fees (deductible in United States' terms) for which patients are responsible. These fees vary with inpatient care costing the least and a visit to a private practitioner costing the most. More than 90% of all physicians are public employees. The balance of the cost of medical care is paid at fixed rates by the Swedish Social Insurance System. Regardless of specialty, all doctors with equal positions and equal lengths of service are paid similar salaries for the same number of hours of work.

TABLE II

INTERNATIONAL HEALTH CARE INDICATORS, SELECTED YEARS

Health Care Indicator	Sweden		England/ Wales		United States	
Infant Mortality (per 1000 live births, 1973)	9.9		16.9		17.7	
Maternal Mortality (per 100,000 live births, 1973)	2.7		11.2		14.1	
Life Expectancy (at birth, 1974)	M 72.3	F 78.1	M 69.4	F 75.7	M 68.2	F 76.0

HEALTH SYSTEM CAN KILL

The health indicators in Table II point out the differences between the United States where health care is controlled by the private sector and other countries where health care is controlled by the public.

Proponents of the present health care system argue that the U.S. cannot be compared to other countries because the demography, life styles, nutritional habits and economic situations differ vastly. Although this argument has some merit, the fact is that the U.S. health system has not been able to improve America's life expectancy and maternal and infant mortality rates to the extent achieved in other Western countries. In light of these statistics the argument that other variables influence the health status of the population is not strong enough to support the conclusion that the U.S. medical system is adequate and should not be changed.

WHY RATIONALIZE?

The American health care system is being forced toward a national system in which the country will be divided into geographically, socio-economically, politically and culturally distinguishable areas in which the medical delivery and education system will be regionalized. The motivations to regionalize fall into three basic categories:

1) *Social motivations*—The desire for social justice demands an end to the inequities in the distribution of resources among the geographic areas of the country and the socio-economic and age groups in the population. Only the national government can evaluate and establish priorities designed to redistribute scarce health resources throughout the country. With a rational nationwide health care delivery and education system, research designed to determine health care needs can be translated into the distribution of resources to publicly accountable administrative units.

2) *Scientific and technological motivations*—The sophistication of medical care makes the definition and delivery of quality care based on medically determined need a realistic possibility. This is seen in the growing concern over adequate use of specialized personnel to ensure the maintenance of skills and currency of knowledge of new developments; interest in research studies concerning the appropriateness and timeliness of treatment; and recognition that medical education must be integrated with the needs of the population. Additionally we are increasingly able to prevent certain diseases. The goals of and functional relationships within a regionalized system are especially designed to address these areas of concern, i.e. medical education based on population need, efficient and effective utilization of specialized personnel and equipment, an emphasis on prevention, rational referral systems, and ongoing education and training for all personnel.

3) *Managerial and economic motivations*—This category includes most of the arguments frequently heard today: the scarcity of resources; the need to maximize productivity and increase efficiency; the savings possible with unit pricing; the possibilities of economies of scale; and the general need for better management control and increased accountability.

REGIONALIZING: THE STYLE THAT COSTS LESS

Regionalizing the delivery of personal health care into primary, secondary, tertiary and preventive care thus assuring the treatment of disease at the appropriate level or intensity promotes less hospital usage than currently exists in the United States. A study conducted by InterStudy for the Department of Health, Education, and Welfare and released in October 1976 reported that "there is substantial evidence of excess hospital capacity which contributes significantly to medical cost escalation with little or no benefit to health. If done in an orderly and appropriate manner, it would appear that hospital capacity in the United States could be reduced, conservatively, by at least 20% or more without harm to the health of the American people...(R)esearch suggests that a reasonably well organized health care system could adequately serve the U.S. population with as few as 600 to 800 patient days or less per 1000 persons (equivalent to 2.0 to 2.6 beds per 1000 at 85% occupancy)...In contrast, the present U.S. average is 1200 patient days (and 4.4 beds) per 1000 persons." As this report points out, excess hospital capacity does not necessarily promote poor quality care (although vacant beds tend to be filled with persons who might be equally well treated at a lesser intensity or level of care) but it does significantly increase the cost of care. According to this study, "In 1975, an 8% reduction in annual hospital expenditures nationally (representing a 10% reduction in hospital capacity) would have amounted to (a) $3 billion (savings)."

The incentives of the current health care system (insurance which covers inpatient but not ambulatory care, third party coverage which writes a virtual blank check to hospitals and physicians, and certificate of need laws which may successfully restrict bed increases but do not address increases in labor and capital intensity) are geared to over-emphasize intensive hospital care and use. The system will not voluntarily reduce its own capacity. Indeed hospitals which individually decide to limit their own capacity are often hurt by competition from other hospitals which have a "spare-no-expense" attitude. Eventually, cost conscious hospitals have their reimbursement rates lowered by third parties.

Regionalization as a style of care is geared to keeping patients well through prevention, and, when ill, out of hospitals through the extensive promotion of primary care facilities. When hospitalization is required regionalization provides incentives to treat patients at the lowest intensity of care consummate with good quality care.

With authority to make and enforce decisions a national/regional health service could alter the style of health care in the United States. Necessary in- and out-patient capacity could be determined and provided for. Regionalization would provide the organization and coordination to assure the delivery of quality care within a system with restricted bed capacity.

AND RETURNS MORE

A regionalized health care system within a national health service has built-in mechanisms to assure that patients receive treatment at the appropriate level of care. Quality and appropriate level of care are intimately related—not only are patients treated with the intensity of care required by their illness but health professionals are only able to work at the level of care and in the field of care in which they were trained.

The incentive to do unnecessary work is minimized; the fee-for-service incentive to operate regardless of clinical need is removed. In Great Britain where care is paid for on a capitation basis and primary care physicians are not permitted to perform operations for which they have not been trained, surgery rates are half those in the United States. In the United States surgery rates are significantly lower in pre-paid group practices when compared to fee-for-service private practice. In this setting, the financial incentive to provide unnecessary care has been removed and primary care physicians more readily refer patients to specialists. Unfortunately, in the current U.S. system, millions of operations are performed annually by physicians not adequately trained in surgery, and by those who are trained but are lured by the fee to decide in favor of operating when the benefits of the procedure to the patient are questionable. In a system where patients and service to patients are equated with financial gain, referring patients to a more appropriate physician is less alluring than if no fee was at stake. A regionalized national health service in which all physicians are salaried eliminates this inhuman dilemma.

REGIONALIZATION IS NOT...

Many current actions of government agencies and health care providers are masquerading as efforts toward regionalizing health service delivery.

Current actions which have been so labeled include the random closing of hospital beds in areas determined politically to be overbedded; the establishment of affiliations between medical school complexes and community and government hospitals (the primary outcome of which is the acquisition of patients for teaching purposes); and complicated administrative affiliations among hospitals with the ultimate outcome that hospital empires become increasingly powerful and more successfully resistent to public needs and pressures. These are negative actions which disregard the issue of quality of care as it relates to the coordination, integration and appropriate usage of services for the benefit of patients.

IN SUMMARY

The present health system with all its successes leaves too much undone. The results of government planning legislation shows that needed changes will not voluntarily be made and that policy-making and decisions cannot be left to providers and health institutions which must look after their own self-interests. The responsibility must rest with a strong federal government mandate for change and a strong role for consumers.

Consumer Commission on the Accreditation of Health Services, Inc.
381 Park Ave. South, New York, N.Y. 10016

☐ $25.00 Organization Subscription
☐ $10.00 Individual Subscription

ORGANIZATION_____

ADDRESS_____

CITY_____ **STATE**_____ **ZIP**_____

NAME_____ **TELEPHONE**_____

Back issues of **HEALTH PERSPECTIVES** and **CCAHS QUARTERLYs** are available at $1.00 each.

HEALTH PERSPECTIVES

VOL. I	#1 April 1973	The Commissions Program Hospital Profile #1	
VOL. I	#2 Sept.-Oct. 1973	Hospital Reimbursement Rates Blue Cross; Medicaid; Workmen's Comp.	
VOL. I	#3 Nov. 1973-Jan. 1974	Profile of Governing Bodies of the New York City Voluntary Hospitals	
VOL. I	#4 Feb.-April 1974	Profile of Patients' Rights and Hospital/Patient Representatives	
VOL. I	#5 May-June 1974	Open Heart Surgical Facilities in New York City area	
VOL. I	#6 July-Aug. 1974	Freedom of Information— The Right of the Public To Know	
VOL. I	#7 Sept.-Oct. 1974	Hospital Inspection—Its Importance to Consumer	
VOL. I	#8 Nov.-Dec. 1974	Health Dept. Reports on HIP Importance to Consumers	
VOL. II	#1 Jan.-Feb. 1975	Ambulatory Care Program: A Role for the Consumer	
VOL. II	#2 Mar.-April 1975	Hospital Accreditation: Where Do We Go from Here?	
VOL. II	#3 May-June 1975	Malpractice! Consumers' View	
VOL. II	#4 July-Aug. 1975	National Health Care Quality Control: The Alternatives	
VOL. II	#5 Sept.-Oct. 1975	Hospital Reimbursement: Importance to Consumers	
VOL. II	#6 Nov.-Dec. 1975	Clinical Labs: Importance to the Consumer	
VOL. III	#1 Jan.-Feb. 1976	Utilization Review: Importance to the Consumer	
VOL. III	#2 Mar.-April 1976	Health Planning: A Consumer View	
VOL. III	#3 May-June 1976	Full and Equal Participation: A Consumer Objective	
VOL. III	#4 July-Aug. 1976	Health Planning and Reimbursement	
VOL. III	#5 Sept.-Oct. 1976	Surgery: Consumers Beware	
VOL. III	**#6 Nov.-Dec. 1976**	**Hospital Social Work: Consumer's Critique**	
VOL. IV	**#1 Jan.-Feb. 1977**	**National Health Service—I**	
VOL. IV	#2 Mar.-April 1977	National Health Service II	
VOL. IV	#3 May-June 1977	National Health Service III	

CCAHS QUARTERLY

1. Fall 1973	Hospital Accreditation and the Role of the Consumer	
2. Winter 1974	A Comparison of Hospital Surveyors in New York State	
3. Spring 1974	Consumer Experiences in Hospital Accreditation	
4. Summer 1974	Joint Commission on Accreditation of Hospitals (JCAH)—The Lincoln Hospital Experience	
5. Fall 1974	Occupational Safety & Health (OSHA)—A Means To Improve the Health of Americans; Part I	
6. Winter 1975	OSHA and the Health System, Part II	
7. Spring 1975	Nursing Home Transfer Trauma—The Public Interest	
8. Summer 1975	Cancer and Jobs	
9. Fall 1975	OSHA Guides I and II	
10. Winter 1976	Nursing Home Transfer Trauma—Part II	
11. Spring 1976	Health Planning Systems Agencies—Planning for OSHA	
12. Summer 1976	Hill-Burton Free Care Provisions—A First Step	
13. Fall 1976	**HSA and Hospital Governing Bodies—Conflict or Complement**	
14. Winter 1977, Spring 1977	An Occupational Safety and Health Workbook ($4.00 per copy)	

PUBLISHED BY CONSUMER COMMISSION ON
THE ACCREDITATION OF HEALTH SERVICES INC.
381 PARK AVE. SO., NEW YORK, N.Y. 10016
TELEPHONE: 689-8959

Non-Profit Org.
U. S. POSTAGE
PAID
New York, N. Y.
Permit No. 7681