Health Crisis: LBJ Panel Calls for Reshaping American Medicine

Studies of health manpower needs are monotonously predictable. Generally, a panel of experts sifts through statistics, predicts trends, and estimates that the U.S. will need *x* doctors and *y* nurses by such-and-such year to avert a national crisis. The usual solution: an infusion of money to produce a massive increase in the number of health professionals.

Such is not the case, however, with a report released last week by President Johnson's Advisory Commission on Health Manpower.* The report refuses to play the numbers game and, in fact, recommends no specific manpower levels beyond stating that more personnel are clearly needed. Instead, it suggests a basic "reshaping" of the nation's health care system to hold down costs, upgrade quality, and increase the availability of services. Included among its more than 50 recommendations are proposals for widespread quality control of medicine, periodic relicensing of doctors, and financial incentives to increase the efficiency and quality of care.

Why are fundamental changes necessary? Because the popular notion that a health crisis is "upon us now or just around the corner" is correct, the commission says. Long delays to get a doctor's appointment, long periods spent in the aptly named "waiting room," hurried and impersonal attention, uneven distribution of care, shortage of beds in one hospital while beds in another lie unused—all attest to a growing national emergency. "There *is* a crisis in American health care," the commission says. "*The crisis, however, is not simply one of numbers. . . . Unless we improve the system* [original italics] through which health care is provided, care will continue to become less satisfactory, even though there are massive increases in cost and in numbers of health personnel."

The commission emphasizes that it is not advocating a master federal health plan, a national health service, federal regulation of costs and quality, or massive federal spending. On the contrary, it seeks a "creative partnership of public and private enterprises" because "government alone is not big enough to solve the problems." The commission's numerous recommendations would require voluntary action by universities, the health professions, hospitals, insurance carriers, and other private organizations, as well as action by the federal and state governments.

Unlike some advisory reports, this one has caused a stir in the highest government circles, perhaps because its bold recommendations fit in well with the administration's desire to mold a greater society without vast federal expenditure. President Johnson himself told a news conference: "I believe the report should be required reading by all cabinet members. . . . I am asking every department of this government concerned with health care to carefully evaluate and study every one of these recommendations." Several of the nation's most influential newspapers, including the New York *Times* and the Washington *Post,* have already endorsed the report. But considerably less enthusiasm has been shown by some health professionals. The administrator of one distinguished hospital told the commission: "It's so bad I won't comment on it."

The 15-member commission was headed by J. Irwin Miller, chairman of Cummins Engine Company of Columbus, Indiana, who was recently nominated for the presidency of the United States by *Esquire* magazine. The most significant member, from a "practical politics" standpoint, was probably Dwight L. Wilbur, clinical professor of medicine at Stanford University School of Medicine, who is president-elect of the American Medical Association. His backing of the report may indicate that the upper levels of organized medicine will work to implement the controversial recommendations—despite the probable opposition of many doctors. Key staff members of the commission included Peter S. Bing, formerly with the Office of Science and Technology, who served as executive director, and Vincent D. Taylor, program manager of health research for the RAND Corporation.

The commission's call for fundamental change is based on evidence that present American health practices result in much high-cost, low-quality care. From a cost-versus-benefit standpoint, for example, American medicine is becoming an increasingly poor investment. The commission estimates that, if present trends continue, hospital costs will increase by more than 250 percent in the decade ending in 1975 and expenditures for physicians will rise by about 160 pecent—well above an anticipated general price increase of only 20 percent. These soaring costs might be more acceptable if they brought "dramatic increases in health," the commission says, but life expectancy—the only reliable national health indicator available at present—has shown a "barely perceptible increase" in the U.S. since 1954. The commission suggests that expenditures for other goods and services which influence health, such as environmental sanitation and better housing and education, might improve health more than comparable expenditures for medical services.

The commission also found a serious "quality gap" between the latest advances in medical science and technology and the treatment being given patients. "Deviations from best practice appear to be significant and widespread," it said. A 1962 survey of 430 patients admitted to 98 different hospitals in New York City, for example, found that only 31 percent of the general medical cases received "optimal" care. And a recent survey of medical laboratories by the Public Health Service found that 25 percent of reported results were erroneous. Moreover, large segments of the population receive little or no care whatever.

The commission was remarkably unanimous in its recommendations for

* Commission members included J. Irwin Miller, Cummins Engine Company, chairman; Joseph A. Beirne, Communications Workers of America; Mary Bunting, Radcliffe College; James C. Cain, Mayo Clinic; Albert Dent, Dillard University; Robert H. Ebert, Harvard Medical School; Gaylord A. Freeman, Jr., First National Bank of Chicago; Kermit Gordon, Brookings Institution; Russell A. Nelson, Johns Hopkins Hospital; Quigg Newton, Commonwealth Fund; Charles E. Odegaard, University of Washington; Thomas Vail, Cleveland *Plain-Dealer*; Joseph F. Volker, University of Alabama; Dwight L. Wilbur, American Medical Association; and Alonzo S. Yerby, Harvard School of Public Health. Their "Report of the National Advisory Commission on Health Manpower," vol. 1, is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402; 45 cents.

changing the system. No effort was made to reach consensus, yet only three members dissented from any part of the recommendations and the dissents were on issues that did not undermine the main thrust of the report. The most important—and in some ways most radical—recommendations involve financial incentives and penalties to increase both the efficiency and the quality of hospital care. The commission found wide variations in cost among hospitals—more than 100 percent in some surveys—and it blamed these variations on "the almost total lack of economic incentives for efficiency or mechanisms that would force the inefficient to improve or go out of business." Wide cost variations showed up in all aspects of hospital operations, from nursing to the purchase of pork chops.

Some current practices actually encourage inefficiency. The Medicare and Medicaid programs, and some private insurance plans, notably Blue Cross, reimburse hospitals on a cost or cost-plus basis for care rendered their subscribers. Thus, in a group of hospitals rendering comparable care, the least efficient ones—that is, those with the highest costs—receive the largest payments, while the most efficient ones get less. To reverse this situation, the commission recommends that the federal government and health insurance groups experiment broadly with new payment formulas. It suggests several approaches, all based on the principle that hospitals in a given locality should get equal pay for equal service and should reap greater financial rewards as they upgrade the quality of the care they give or increase their efficiency in delivering it. Quality would be evaluated by peer groups of medical experts. Grossly inefficient hospitals would be paid less than their costs and would, presumably, be forced out of business. Significantly, legislation that would enable the federal government to experiment with new formulas is embodied in the Social Security amendments that are expected to be adopted this year.

The report is laced with other incentive schemes to provide efficient hospitals with capital funds for expansion, to encourage medical schools to expand and improve, and to give doctors—the key factor in determining hospital utilization—a financial stake in hospital operation and membership on hospital boards. But the commission failed to come up with an incentive plan covering doctors' services outside the hospital, apparently because of practical difficulties and the relatively smaller savings that would be likely to result.

The incentive schemes rely heavily on another set of recommendations that is bound to be controversial—the widespread use of peer review groups to monitor and evaluate the quality of care rendered by hospitals and doctors. Such peer review is already being practiced, on a limited basis, by hospital tissue committees, Medicare utilization committees, medical society grievances committees, and other groups, but the commission wants to apply it on a massive scale, using peer review routinely on virtually all hospital and medical cases.

The commission envisions a variety of review mechanisms, all operating at the local level under the supervision of professional societies. One scheme mentioned favorably is run by California Blue Shield, which uses a computer to scan its records for "significant deviations from usual practice" and then forwards the records of these questionable cases to the county medical societies for investigation. Offending doctors may lose their Blue Shield payment or even be suspended permanently from the Blue Shield program.

In the present state of the art, it is expected that peer review would focus primarily on whether a doctor took appropriate action in a given situation, and would seldom get into the much tougher question of whether he performed the appropriate action well or badly.

Other key recommendations of the commission include the following.

► State governments and professional societies should explore the periodic relicensing of doctors and other health professionals to ensure that they keep up with the latest knowledge. Relicensing might be granted on the basis of completing a continuing education program or passing a chal-

A POINT OF VIEW

S. Dillon Ripley, Secretary of the Smithsonian Institution, in an address on international cultural relations, 19 October, at New York University.

[In] the exchange programs connected with our foreign aid, specifically those of the Agency for International Development, you will find far more public officials—ranging from chiefs of police, to whom we impart our vastly successful experience in riot control, so that they may use it back home with subversive groups, to aviation administrators, who are left to gaze in awe upon the complex air traffic structure of our eastern megalopolis—you will find far more of these officials than you will find ecologists or demographers, who represent professions in which AID ought to have more than a passing interest. . . .

[You] will find that on university campuses, it is the student politician, rather than the student who is becoming a scholar, that goes to the great international congresses or gets the red carpet tour. This is something, you will recall, that our National Student Association discovered rather belatedly, to its chagrin.

But let me point out also, again to spare my colleagues in Washington from total blame, that the United States is not alone in the business of trying to change attitudes through what is called cultural or educational exchange. Groups of foreign journalists, student leaders and union chiefs are not unknown in the USSR. . . . But this game of trying to serve the national interests through international cultural exchange is wrong if it is played at the expense of scholarly exchange. It is doubly wrong if another kind of game is played behind the mask of scholarly exchange, as we have reason to know, because the exposure of counterfeit scholarly communication can cast doubt on real communication among all scholars. The game is also wrong, as I have said, if we expect too much of it. We will be wrong if we keep looking anxiously for a victor, for there can never be one.

lenge examination in the practitioner's specialty.

► The U.S. should produce enough physicians to meet its own needs instead of relying heavily on some 40,000 foreign-trained physicians who currently comprise 14 percent of the active physicians in this coutry. The U.S. should also help other countries improve their systems of medical education and health care.

► Foreign-trained physicians who have responsibility for patient care in this country should pass tests equivalent to those for graduates of U.S. medical schools.

► The production of physicians should be increased by substantially expanding existing medical schools and building new ones. Paradoxically, the doctor shortage is worsening even though the ratio of physicians to population is improving. This is because various demands cut into the amount of time available for direct doctor-patient contact.

► Universities should supervise the formal education of all health professionals, including such graduate training as internships and residencies, in order to eliminate the present "uncoordinated" system in which as many as five different groups may be involved in educating a single individual.

► Programs for health care of the disadvantaged should be given highest priority.

► Health-insurance organizations should provide coverage of outpatient as well as inpatient health services so that patients and doctors will no longer be inclined to choose hospitalization when less costly outpatient services would do as well.

► Highest priority should be given to development of methods that will assure easy access to adequate health care, possibly by giving a community health organization or a single ombudsman-like individual responsibility for assuring access.

► Though the commission stopped short of recommending extension of prepaid-group-practice arrangements, it spoke favorably of such plans, particularly of the Kaiser Foundation Health Plan in California, which delivers "high quality medical care for 20–30 per cent less than the cost of comparable care obtained outside the plan."

None of the commission's suggestions is new in the sense that it has never been proposed before. The significance of this report is that, for the first time, an influential, highly visible group has taken up suggestions previously espoused by occasional lonely voices. Says Philip R. Lee, assistant secretary for health and scientific affairs in the Department of Health, Education, and Welfare: "The recommendations are far more radical than anything that has been proposed by presidential commissions or other formal advisory groups that I'm aware of."

The proposals are bound to provoke opposition. Hospitals that have enjoyed an easy cost-plus world are not apt to clamor for change. Many doctors may balk at judging their peers or at being judged in return. And government officials who fought 20 years to enact Medicare are said to be "tired" and reluctant to jeopardize their programs by upending current payment schemes. Moreover, various government agencies have a vested interest in torpedoing specific recommendations. The military, for example, probably won't like a suggestion that it stop using Selective Service procedures to procure doctors to care for military dependents and retired personnel residing in this country. Nor would the Public Health Service, which now serves as a substitute for the military obligation of health professionals, enjoy losing this status. The proposals could easily get bogged down in years of squabbling, but the commission warns that "time is short." Chairman Miller told a press conference that the nation had "problems to solve" until the early 1960's—now it has "catastrophes to prevent."

—PHILIP M. BOFFEY

Education Reform: Britain Tries It Top to Bottom

London. As if taking a text from Darwin, the Victorians made competitive examinations the basis of a system of selection that has shaped British society for a century. Admission to a university depends on the aspirant's success in a sequence of national examinations. A university graduate's career prospects can be profoundly influenced by the class of degree he earns in the formidable final exams. But perhaps the most crucial tests of all have been taken by children in England and Wales at the age of about 11. The so-called 11-plus examinations have determined whether the child in the state school system will join the minority getting the academic schooling that will enable him to compete at all for a university place.

The 11-plus examination is on the way out in Britain, and its passing signals the cresting of a wave of reform and reorganization that is affecting British education at every level. Behind these efforts at reform are an equalitarian attack on the class bias of the education system and a practical realization that the system is failing to meet the needs of a modern industrial society.

Since the war, the British have had the daunting experience of rapidly expanding university capacity and of spending more than their Western European competitors on research only to see themselves outdistanced in rate of economic growth. Disturbingly, there are empty places for scientists, engineers, and technologists in Britain's otherwise overcrowded universities, and the proportion of secondary-school students interested in science has declined.

Faith in the simple formula that spending on technical education and research brings economic felicity has proved naive, and the British have been compelled to inquire into questions of management, professional values, and social attitudes. One of the results, reinforced by acceptance of the post-Freudian principle that early influences on the individual are decisive, has been a rise in sentiment for reform of primary education, which, in Britain, covers the ages 5 to 11.

The mechanics of reform in Britain are dictated by the structure of an educational system that is neither as centralized as the French and most other