“Medical Care As Social Policy: The Case of Child-Health Services”

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THE SPEAKER

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From 1965 to 1968, Dr. Silver was Deputy Assistant Secretary, Health and Scientific Affairs, Department of Health, Education and Welfare. His professional experience includes the private practice of medicine and positions as Chief of the Division of Social Medicine, Montefiore Hospital, New York City (1951-65) and Executive Associate for Health Affairs, Urban Coalition (1968-70). He has also held academic posts at Jefferson Medical College, Johns Hopkins University School of Hygiene and Public Health Columbia University College of Physicians and Surgeons, and the Albert Einstein College of Medicine.

Dr. Silver is a member of the World Health Organization’s Expert committee on Medical Care and of the National Council of the Federation of American Scientists. From 1960-75, he served on the Technical Board of the Milbank Memorial Fund.

THE OCCASION

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PART I

INTRODUCTION

It is certainly appropriate to discuss medical-care policy issues in the city of Chicago, where powerful professional organizations representing medical care have their seats; where a colorful health officer, who helped usher in the sanitary revolution in the United States, had his office; where Michael Davis, the pioneer in medical-care organization whom we celebrate in this lecture, did an important segment of his creative work. There is some sadness and some irony in looking back at a Davis paper like the one published in 1916, in which he talks about the “coming” national-health insurance wherein medical resources must be devoted to improving medical care as a public service.

It is also appropriate to be discussing international comparative aspects of health- and medical-care policies under the auspices of the Center for Health Administration Studies since one of the pioneers in that field is the Director of the Center. Dr. Anderson has not neglected consideration of the topic selected for today’s talk. In a recent book, he offers a bit of wisdom and a warning: that the “orientation” of a country has a more important influence on the shape of its medical-care system, and by extension its health policy, than the nature of the need, availability of resources, cost, or theoretical issues in debate.

Last year, Professor Wildavsky, the Davis lecturer, beguiled us with a variation of the architectural doctrine that less is more. While I have no quarrel with this philosophy, I am con-
cerned with how much less, particularly for children. I also wonder whether we cannot learn to accomplish more for less; less money, perhaps, along with more prevention and less inequity in the system.

My own professional interest in child-health services began out of curiosity, first about the medical-care system as a whole. Why could not this wealthy, technologically advanced, resourceful country provide modern, high-quality medical care for all its citizens? Why could not the country that made the great leap into scientific attainment of industrial objectives cope with the scientific organization of medical-care services? And what was missing in all the legislation aimed at correcting deficiencies in the medical-care system, backed up by enormous quantities of taxpayers' money?

Failure to provide effective child-health services is even more apparent. In a recent survey, nearly 5 million children were shown to have no source of medical care; 40 million children under age seventeen—more than half of the child population within that age range—had not had a physical examination in two years.

• Over a quarter of preschool children had not been immunized at all. On entering school, 17 percent of the children have defective vision, largely not corrected. Nearly 40,000 children under seventeen are deaf, many without hearing aids; over 500,000 children have speech defects, but a large number are not in treatment.

• As for poor children, they do not grow as tall as other children; suffer more from anemia. In rural and ghetto locations, children still suffer from impetigo, parasitic infestations, and lead poisoning, which are not prevalent among well-to-do children; and they lose more school days to illness than do more privileged children.

• Minority status compounds the disadvantages imposed by poverty: mortality rates are higher at all ages and almost twice as high for infants; nutritional deficiencies are found more than three times as often in minority children.

• Poor children get fewer medical services despite greater need; poor pregnant women and minority women are 50 percent less likely to get prenatal care, four times as likely to die in childbirth.

• Gonorrhea, drug abuse, and child abuse reflect some of the newer problems of child care. Nearly 12,000 cases of gonorrhea were reported in children under age fifteen; 21,000 children between the ages of ten and nineteen were seen in emergency rooms for drug abuse; an estimated 2.5 to 4.5 million children are subject to neglect and mistreatment severe enough to be categorized as "child abuse."

Although largely wiped out in the United States, diphtheria still has occurred as an epidemic among Chicano children in San Antonio, Texas; and among Indian children in Arizona and New Mexico.

To what can we ascribe the cause of the failure to care properly for our children? We have laws prescribing care; we have appropriated billions of dollars to carry out those laws. How does it happen that we fail to find and treat all the handicapped children, fail to provide immunizations and all the preventive and health-educational services needed?

With a small group of colleagues I spent four years searching for causes, reviewing particularly the federal-state relationship in carrying out the two laws (Titles V and XIX of the Social Security Act) authorizing practically all federally supported health care for children.

It turns out that many factors are at work: traditional professional methods of service, for example, without outreach programs, which cannot then bring the poor, the disadvantaged, the uneducated, the isolated under care. School-health services are fragmentary, largely lacking. Politically, there are bureaucratic tan-
gles and overall a lack of advocacy. It isn’t lack of resources or money; it’s lack of effective application of the resources and money.

Those who speak contemptuously of a “non-system” when they discuss the medical-care system in this country are wrong. There is a system of medical care, which in spite of inefficiencies and duplications and lacunae, serves many people well, the professional providers very well.

In the American political system, interest groups have an impact on legislation proportional to their vocal strength, economic power, numerical strength and/or voting power. Children lack an effective interest group, as do others who fail to benefit from the system.

Perhaps the problem is not one of health policy entirely, although children suffer differentially more, but a matter of social policy. Health policy is never really an independent factor. It is a matter of the well-being and overall care of the child. It includes the need to be well born (i.e., healthy) into an environment that is protective and nurturing. It includes prenatal care and attention to nutrition as well as health and medical care for the mother. A decent environment for the child after birth is required: good housing, nutrition and a solidly secure family life. Properly organized and supervised day care is needed for children whose parents are working or are out of the home. A protected environment for all such children of whatever age, before and after school care if need be, is essential. Social policy concerns itself with educational policy as it affects the child’s health, financial security of the family (children’s allowances, for example, may be crucial to child-health policy), and the psychological state of parents as well as children. This complex of factors can be called “social nutrition.” “Social nutrition” is more important for children and for the aged than it is for adults in their productive years. Poverty exaggerates social needs in these periods of life. So we can’t be satisfied with health programs alone, no matter how well designed, or how effective, unless we provide “social nutrition” as well. But we certainly cannot have good social programs unless we have a good health program. Health is a basic building block of “social nutrition.”

The questions raised about America suggested a look at some other countries. After all, if health policy is native-grown, the shape of it determined by history and tradition, social policy is also a native product. What happens to children in other countries with similar resources and standards of living and similar, if not identical, religious and socio-cultural heritage?

We have observed the ill effect of the present disorganized, scrappy, and ineffective child-health service for most children in the United States. It will be useful to compare the health-care system of some other countries to see whether children there are cared for better. In the process, we may be able to establish (a) whether the universal entitlement, which is characteristic of European medical care systems, is sufficient in itself to provide children with all the care they need; (b) whether the social supplements provided families in most European countries are a necessary, or critical, part of the health-service system for children; (c) whether special child-health services are needed despite universal entitlement to medical-care services and/or supplemental family allowances.

PART II

International Comparisons and Implications

The notion of comparative study as an aid to improvement of national performance is not new. In the medical field, we have borrowed the idea of the physician assistant, and we can take credit for inventing the proprietary medical school, if we like, and for the clinical clerkship as an educational tool.
But there is a large question mark in making international comparisons. Social institutions define themselves, based on traditional national values and the special economic and political structure out of which they grew, so that international comparisons can be complicated.

A comparison of health systems alone tells nothing about how to go about achieving desired change. Furthermore, it tells nothing about why a particular pattern of service is included in one country, but not in another, despite similar or even identical need. Britain has a National Health Service, but then it had a National Health Insurance Program fifty years ago. Canada separated from Britain, "severed its colonial status," nearly 100 years later than the United States. Canada now has a National Health Insurance Program while the United States still has not. Canadian custom and social behavior would seem to be closer to Britain than to the United States. France, losing several generations of young men in nineteenth century wars, initiated family and children's allowances to offset declining birth rates in a frantic pronatalist policy, before other European nations.

Bismarck moved to maintain the balance of power amid the squabbling, barely united princely German states and also moved against the threat of trade union action by giving Germany social insurance (including health insurance) before other European states. Cholera in successive waves and the radical political threat of the Chartists strengthened reform action and gave England a strong health department early. The British rely on, and have faith in, governmental health services. Distrust of government in America is widely felt, and individual independence is a notable quality that Americans admire.

The United States, with its worship of technology, early focused on delivering clean milk to infants. The sanitary revolution was successful in the United States long before it was in Europe. Given such facts, it is not surprising that child-health practice and services and social policy did not achieve the (a) governmental nature; (b) public investment; or (c) family and children allowance, which characterized and advanced child health practices in Europe.

Social values and priorities vary from country to country. This, in turn, influences the possibility of national legislation. Admiring other countries' programs is not to say that desirable programs can or will be adopted. That we do not have as advanced a social policy as other countries may not be so much that we despise the poor, as some sociologists maintain, but that our social vision is still anchored in the frontier, in memories of periods when work for everyone was available and self-help was possible. A strong strain of puritanism in our culture also considers poverty something of a sin. American society has to be reminded from time to time that there are people who are helpless and need protection. A Dorothea Dix or Isaac Ray has to step forward every once in a while to scold society for its insensitivity and punitive behavior toward the sick and helpless. In comparison of international activities, much of what we learn can be applied in this country only very cautiously.

There are some other difficulties in direct application of comparisons, too. In the United States, an M.D. is a college graduate and a graduate from a medical school. In other countries, a university alone or a teaching hospital alone is the site of medical training; or one may be called not "doctor", but "läkar" or "vrach" or "arzt". These are healers, of course, who carry the same burden as physicians with an M.D., but they have gone through a different process and will, therefore, express different values about their duties and responsibilities. Governments will deal differently with these various types. Practice expectations dictate different values in the form and substance of medical care. Eliminating the emergency service
from calculation of medical responsibility by setting up a separate medical care system may increase the work load per doctor or reduce it. One has to explore the operation of the system itself, not count doctors or patient visits. 

Whether or not private practice is allowed (or carried on at all) in a medical-care system based on government-paid service can confuse and distort comparisons of availability and access to medical care.

As with doctors, so with nurses. The United States uses the designations "R.N." for graduates of two-, three-, four- and five-year training programs. Some countries have specially designated child-health nurses. A British Health Visitor has had hospital nursing, midwifery training, and at least one full year of specialized training.

Examination of the workings of medical-care systems in societies other than our own, therefore, needs to consider the goals we share, not simply system structures. If we share a common objective, a comparison of different systems may allow us to see what can be borrowed usefully and in what degree.

A review of child-health programs in Europe must have as its objectives then, not only to establish how European social policies differ, if at all, from our own, but also to determine whether their child-health-care structures serve children more effectively, and if so, which elements of these child-health-care systems could usefully be recommended for improvement of our own child-health-care system.

Specifically, answers to three questions were sought:

(1) Is universal entitlement to health- and medical-care services a sufficient guarantee for provision of comprehensive child-health services?

(2) Is there a need for a separate preventive health service for children?

(3) Is there a role for the private sector, or is a successful child-health program necessarily an official function?

Although originally a test of the need for "social nutrition" was considered, there is no way of determining its essentiality, since every European country has family and/or child allowances.

PART III
Observations on Some European Children's Health and Medical Care Systems

For comparisons to be useful, it is important to select for study countries in which comparability of data would be most closely related to United States experience and customs. Two European countries, Scotland and the Netherlands, conformed particularly to the desired qualifications and were studied in some detail. In addition, with the assistance of WHO (both the international offices in Geneva and the European office in Copenhagen), as well as the Department of Social Medicine at the University of Copenhagen, some pertinent information on Denmark, Sweden, and Finland was made available. Conversations were held also with officials in Belgium and France, and documents collected from those countries.

Scotland offered an experience of particular value because the language and culture of the British Isles is reasonably close to the language and culture of our own country. The National Health Service in Scotland, however, is held to be controversial in the United States; it operates through capitation and salary reimbursement mechanisms for physicians, official control of hospitals, and a budgeted health economy. Holland offered comparisons of particular value in that the medical-care system there (except for the existence of national health insurance) is similar to our own—private practice, fee-for-service, a voluntary hospital system.

Both countries provide universal entitlement to medical care through their national health programs—insurance in Holland, a tax-
supported service in Scotland. As for a specifically designated child-health service, this existed in plan and operation in Holland, but was in a confused state and incompletely operative in Scotland.

In Scotland, barely two years after a comprehensive and radical reorganization of the National Health Service had been instituted, not all parts of the system had picked up the new pace or achieved anticipated goals in operation. This child-health service of the National Health Service had undergone one of the most radical changes of any part of the system, the full effects of which had not been anticipated, and a full counterpoise to the resulting imbalance has not yet been set in place.

While unfortunate for the children, the differences provided opportunity for contrast of the two countries' systems and enabled conclusions that might not otherwise have been possible to be drawn about the need for a separate child-health preventive program.

There was one unanticipated benefit from the selection of these two countries. Holland's devotion to private-sector initiative extends to large-scale support of private agencies for organizing and distributing preventive services. This made it possible to compare programs in Denmark, Sweden, and Finland, all countries with excellent child-health services on a par with the Dutch, but which do not allow for mediation through private agencies, preferring to provide the necessary preventive services to children through official agencies.

The Dutch arrangement is of immediate interest and pertinence to the American scene in view of the distrust many Americans have for government program operation, and the reluctance to use official agencies which seems to be ingrained in the American character. There is also the growing "consumerism" in the United States, demanding that citizens themselves determine and control community services. There is also a centripetal force at work in many communities, intensifying the clustering of ethnic and religious groups, as if to deny the classical "melting pot" attribute of America. "Verzuiling" (columization), the historical Dutch effort to contain religious differences by acknowledging and actually reinforcing them, which is evident in the nature of these private health-agency organizational structures, may appeal to a good many Americans as a solution to the inherent inequities of majority-controlled structures in community services.

Scotland is a beautiful country of mountains, lakes, and islands, sparsely settled, with a population of barely 5 million people, a poor country in which the GNP and the per capita income are significantly less than for Britain as a whole. Unemployment averages twice that of Britain. Most of the population is concentrated in the south—the city of Glasgow has a population of a million—and the so-called "Strathclyde conurbation," including Glasgow, one of the nine regions into which Scotland is divided for political purposes, includes more than half the population of the country.

Data on health indicators reflect Scotland's less-favorable condition: infant mortality for England and Wales in 1970 was 20/1,000 live births; Scotland, 25 (same as the United States); and Clydeside, 28.

The health service is similar to, though not identical with, that in England and Wales.

Child-health services are comprehensive and inclusive by law. Every woman is entitled to prenatal care, provided in either a physician's office or health department clinic; 99 percent of babies are born in hospitals where almost five thousand nurse/midwives and maternity staff handle deliveries with the assistance of less than two hundred obstetrician/gynecologists/specialists and staff in training.

Since we are comparing social policy influencing child-health program design and effectiveness, the workings of the health system will not be examined in detail. Cost is met almost entirely from general revenues appropriated annually by Parliament. Services are
paid for by capitation to general practitioners; by salary or session to specialists.

The Scottish Home and Health Department includes the office of the Chief Medical Officer, whose staff serves as staff for the Health Service Planning Council, which is responsible for health services. Fifteen Area Health Boards operate programs, using a variety of advisory and consultative groups to promote policy and action. The Areas receive budgets and have common responsibilities, but they can adapt operations to local custom as their local committee structure dictates. But national objectives must be attained: in child-health services, for example, it is expected that immunizations, case finding, health education, and school health services will be carried out. National salary levels and professional standards are observed.

There are advantages to this uniformity with modest flexibility. Nevertheless, the uniformity tends to inhibit innovation. Traditional approaches, however modified, for example, may not be useful enough in the face of gross differences in housing, unemployment, or the size of welfare rolls.

A demonstration project in one part of Scotland, although in operation for many years, has not resulted in marked change in child-health programs elsewhere because it requires system changes to be more widely emulated. Not that it would be easy to make radical system changes in any country, but it might be accomplished in Scotland alone, if it did not mean that it would have to be done in England and Wales as well.

In the field, about one thousand health visitors carry the major burden of well-baby care, prenatal care, home visiting, and health education. The transition from the older system of child services (before 1974) to the current one has not been smooth. Before 1974, the local authorities were responsible for prenatal and well-baby care, employing the nurses and health visitors to carry out these tasks. The local authorities also employed public-health physicians, usually of general practitioner calibre without special training in either public health or pediatrics. By arrangements with the educational authorities, these physicians, or others like them, also under the aegis of the local authority, provided school health examinations and referrals, with the assistance of the health visitors and school nurses.

Since 1974, drastic changes have taken place in political structure, funding arrangements, and health-service organization. There are no more local authorities. There are nine governmental regions, politically, which are neither congruent with nor administratively or fiscally related to the fifteen Area Health Boards. There are no local well-baby, prenatal, or school health services unless the Area Health Boards organize and pay for them. The Area Health Boards have fixed budgets and assign priorities to locally decided responsibilities, so that not all boards will assume full responsibility for all previous local health authority responsibilities. Supervision is the field of the Community Medicine Specialist, a new position created as part of the reorganization for a person with professional (medical), public health, and managerial training and experience and skills. This is a difficult burden, and in view of the overall transition it is not surprising that a good deal of what was to be accomplished by this new role still remains to be done.

In addition, the public-health physicians who had served with reasonable success as preventive-medicine workers for preschool and school health services no longer have a secure place in the new hierarchy.

A second factor that has obstructed the fulfillment of a child-health service in the newly reorganized medical-care system stems from the honest endeavor over the years to improve the status and functioning of the general practitioner. It is expected that the general practitioner will take over all the responsibilities for prenatal and well-baby care, examining the infant periodically, and acting as the consultant to the health visitor, as the public-health doctor in
the clinic did formerly. The health visitor has been taken out of the clinic and placed in the doctor’s office, especially in the new health centers being built by the Health Boards to encourage general practitioners to practice in groups. Ideally, this is intended to foster a form of specialization along lines of interest in the groups. All the colleagues would remain general practitioners, but each has an opportunity to do more in some area of medicine he likes particularly. It is hoped that at the same time the universities and teaching hospitals will take these semi-specializing g.p.’s. under their wing, give them some staff standing, educational opportunity, and lots of consultations in the hospital and in their offices, in order to retain the quality of child-medical services.

This has not turned out exactly as planned. The doctors took eagerly to the use of the health visitor in the office. However, since sick people get priority over well, more and more attention has been paid to the needs of the elderly, who had not previously had all their medical needs met at home. The general practitioner is more likely to send a health visitor to care for a sick old person than to encourage a health education visit to a well-baby’s family. The general practitioner is more likely to embrace a semi-specialty that reflects the needs of the sick in his office practice than to specialize in wellbabies. So children get less than anticipated in the way of examination, handicap-finding, and social and psychological guidance for themselves, for their families, and for the teachers.

Statistics do not show how much is being done for prevention and child care by the general practitioner. But one can see that immunizations are declining, particularly measles immunizations. The number of women attending prenatal clinics has practically halved over the past five years.

The deficiencies of service do not stem from lack of resources. As compared with England and Wales, Scotland has a health budget proportionately greater; more doctors per 100,000 population; more nursing staff proportionately; and more hospital beds comparatively. But, health visitor visits to old people are 50 percent greater proportionately, despite the fact that Scotland does not have proportionately more health visitors.

There is some controversy as to the responsibility for the seeming decline in preventive care. Professionals tend to “blame the victim.” Increasing unemployment and un-replaced poor housing play their part in producing more “multi-problem” families that have to be dealt with by the same size health worker force. Others consider personal characteristics of a changing population to have some weight as well. The Strathclyde conurbation has a large, impoverished Irish immigrant population. Unemployment, poverty-level families, and housing in Dundee, northeast Scotland, are not too different from Strathclyde. Yet the public-health data are quite different. When Glasgow’s infant-mortality rate was twentyseven (1970), Dundee’s was nineteen, for example. Scotland does have more poverty, poorer housing, greater crowding than England. And the “urban complaint”—insufficient social services and multi-problem families—would seem to be good reason for the lesser effectiveness of the Scottish Health Service.

In addition, practitioners and health officials in Scotland agree that the dilemma is complicated by many factors: the lack of sufficient health visitors so as to look after the aged as well as reach out to the children; lack of a priority schedule of visiting to specially disadvantaged families; the irresolute stand of general practice on pediatric care; all play their part. Also, Britain is in economic difficulties. A heavier social investment is needed in view of the reorganization of social, political, and educational systems and the National Health Service, which has made for confusion, ineffectiveness, and complicated failures here and there as the administrative units and officials
try to make the new and awkward machinery work. Reports from Scotland ("Toward An Integrated Child Health Service") and from England and Wales ("Fit for the Future") indicate how fully the British people and their professional classes understand this and intend to make it work. It isn't working yet. Universal entitlement to medical care is clearly insufficient in itself to provide a comprehensive, equitable child-health-care system.

Holland is a smaller country than Scotland, but it has two-and-a-half times the population—13 million people. It is a rich farming and dairy country, as well as a major industrial and shipping center, densely populated. One can speak of "rural" areas, but hardly any part of Holland is far from an urban center. The short distances between communities and the excellent system of public transportation minimize any problem of getting or giving social, including health, services.

From a standpoint of statistical comparison of health indicators, Holland is probably the "healthiest" country in the world; regarding child health, that observation is unquestionably so. In 1972, the infant mortality rate was 11.7 per one thousand live births, when Scotland's rate was 18.5, England's and Wales' 17.3, the United States' 18.5. Over 98 percent of the Dutch children are immunized against the preventable diseases, and all Dutch children are examined for handicapping conditions within six weeks of birth, if not immediately in the hospital. Again, by law, Dutch children are examined at least four times before school entrance, on school entrance, several times during their school attendance years, and upon leaving school (age 16). If they continue in school, students are subject to further mandatory physical examinations. The information is collected and published, so that the data on school health, handicapping conditions, and status of treatment is known and recorded.

The Dutch not only maintain lists of the handicapped children, but assign priorities for visiting those where there is a record of need and no evidence of treatment. The social services, educational services, and the courts cooperate in finding and guaranteeing children the medical care they need.

Treatment of illness is mediated through a system of private medical practice, general practitioners, specialists, and voluntary hospitals, very much as in the United States. However, the care is paid for by a governmental insurance program for ordinary and for long-term care. Funds are collected from employee, employer, and the state. Fee schedules, hospital costs and salaries are negotiated on an annual basis between the medical society and the insurance agencies. Nearly everyone is a member of one or another insurance plan, including self-employed who can "buy in." Patients never see a doctor bill or hospital bill, nor do they lay out money at the time of service. The cost to the patient, in terms of the percentage of the cost that comes from his wage packet, may be somewhat higher in Holland than in Scotland. Universal entitlement to medical care for children is, therefore, the rule.

However, in addition, there is a complete children's preventive service, which it is the role and function of the National Health Service to provide or arrange. The National Health Service's other function is supervision of the health of the Dutch people, which includes not only epidemiological and environmental supervision, but supervision of the medical-care and health-care systems to assure their quality, economy, efficiency, and satisfaction to the consumer. In addition to a Director General, the National Health Service employs inspectors, who have parallel staffs to carry out their function. There are provincial suboffices and subinspectormates to carry out the duties.

Children's preventive services are largely provided through "Cross" organizations. These "White," "Green," "White-Yellow," "Orange-Green" "Cross" units, private groups to which members pay dues, train and employ
a special category of children's nurses to provide well-baby care, home visiting, examinations of children, immunizations, family advice and guidance in child rearing, and specialist consultations where indicated.

Physicians are employed to give supervision and some direction to the service. The "Crosses" contract to provide the preventive services mandated; agree to supervision and budgetary controls, as well as to the payment of salaries and fees negotiated by professional groups in the state; and in return, receive sufficient funds from the National Health Service to make up their operational deficits.

The Dutch word for the process is "verzuiling," which means "columnization," and refers to the fact that originally, religious preference was to extend like a column through all the aspects of community life: housing, education, social services, even work. This has been greatly modified over the centuries, but there is still adherence to Cross-society organizations in health services.

In the Netherlands, it is only necessary for a group of people to associate themselves in an organization, offer a plan to the government as to how they will provide child preventive services, and receive approval to set up and be funded. There are almost three thousand such organizations in Holland. The Cross organizations are examples of local initiative, local control, and community participation, as well as decentralized administration.

The examination of infants is a necessary condition for receipt of a child's allowance from the State, and as a consequence, every child is examined and every family attaches itself to one or another Cross organization for continuing preventive care and supervision. The relative inefficiency of multiple Cross organizations, particularly where there are relatively small memberships and consequent difficulties in maintaining staff, has given rise to efforts at amalgamation. In large cities like Amsterdam, the community has taken over the responsibility for providing all the services through its own clinics. Nevertheless, in 1973 there were over 3 million members of the various Cross organizations and they employed almost four thousand nurses.

There is strong legal support for child health, also. Holland specifically provides that where there is evidence of neglect or abuse of the child, a "medical referee" be appointed by the courts to be the child's medical guardian. Devoted as the Dutch may be to liberty, our concerns about confidentiality, privacy, and the primacy of the family in child care go by the board when it comes to a child's health. The child's health comes first, not theoretical philosophical principles.

The Swedes and the Danes carry this a step further. Local councils establish a Committee on Youth, headed by an elected Council member. Their job is to get information on and be aware of whatever is happening to children in their community and, where there is neglect or abuse, to do something about it.

No child escapes immunization or treatment for handicapping condition because he falls through the administrative net. For example, a few thousand children are not registered with municipalities because the parents are nomadic in their occupations—gypsies, or barge operators. These children might be lost in some giant bureaucracy; not so in Holland. The Director General of Health Services is personally responsible for these children and must be kept informed of the whereabouts of the children and assigns nurses to look after them at various ports of call.

In the United States it is estimated that there are over three million children who need glasses but do not have them. It could not happen in Holland.

The experience of other countries suggests the need for a separate preventive service for children. In France, eligibility for a substantial children's allowance depends on participation in a prevention program, and a record of hand-
icapped children is kept and used as a priority listing for services by the specially trained “puericultrices.” In Belgium, language and cultural separatism gives rise to conflict from time to time, so private-agency preventive-care service is strongly supported. Finland, which has an astonishing record of reduction of infant mortality, relies almost entirely on nurses for a separate and federally funded, locally controlled preventive service for children. In Sweden, nurses provide the care for the preventive system under physician supervision from county funds, without any federal control or supervision, but on the basis of a national standard of care.

These countries have in common a preventive service for children that works. It is a service that relies mainly on specially trained nurses; can be privately operated, but with public financing; and has powerful and effective supervision, an ombudsman approach to protect the child’s interest and rights.

So far as costs are concerned, the Amsterdam Health Officer calls his “an apple a day” because the cost of the entire service comes to just about nine cents a day. Of this, less than a fourth is from the dues that members pay the Cross organization. The various governments—state, provincial and local—make up 60 percent of the cost, and the rest derives from charges the organization makes for services to those not covered by membership, or who are otherwise ineligible.

Summary:

Scotland and Holland both provide universal entitlement to medical care as well as a preventive health service for children. The preventive services in Scotland appear to be less effective than the Dutch, in part perhaps because of recent reorganization as well as economic constraints on development. The Dutch child-health services, though complicated, with separate preventive and treatment services, are closely tied to local community structures, emphasize the private-sector role and strong public financial support, and are quite successful. Both the Scottish and Dutch systems rely to some degree on the general practitioner, but both rely heavily on nurses; the Dutch on specially trained child-health nurses.

PART IV
Conforming to American Patterns

It should be apparent that a good deal of what is being done, successfully, to provide health and medical services to children in other countries cannot be done in exactly the same way in the United States. In some countries, people have learned to accept more government oversight than American citizens are accustomed to.

A national program of child-health care will hardly be accepted in the United States if it is predicated upon a national bureaucracy. Even if the official character could be mitigated by regionalization, it would still be “Washington” in everybody’s mind. A British-style health system for children, even with area health boards, would be difficult to install here.

Whatever can be learned from the experiences of other countries in improving child-care services will not be capable of incorporation into the American scene unless the lessons conform to American traditions and political and social patterns.

In the past two decades, American attitudes have undergone drastic changes. There is a more thoughtful awareness of public and private responsibilities in solving social problems. We know that to carry out national objectives we must avoid bureaucratic management. We are urged to decentralize authority; to foster consumer participation in, if not control of, professional and technical services. Conservative and radical philosophies of public action are converging on these lines. In a recent pamphlet entitled “To Empower People,” Berger and
Neuhaus strongly urge governmental support of what they call “mediating institutions,” meaning the family, the church, and the neighborhood, in helping to heal the injuries visited upon society by the technological revolution, urbanization, and the uprooting of civic structure.

They define the “mediating structures” as “those institutions standing between the individual in his private life and the large institutions of public life.” The Dutch model described above reflects just such efforts.

Americans have a long tradition of association with and involvement in voluntary organizations. We are a nation of “joiners,” a fact noted by de Tocqueville more than 150 years ago. Voluntary and non-profit organizations are an important aspect of American life, not just in the health field. Church, social service, United Way, ethnic and fraternal organizations touch everyone’s life. If a child-care system were to be created along the lines of familiar private, voluntary, non-profit groups and agencies, there is a tradition within which it can easily be accepted. So long as there are national standards, supervised for compliance, to guarantee equity for all the children, local programs may well be operated by private non-profit groups.

It is now commonly accepted that one important contribution to our health—perhaps the most important contribution—would be a radical change in our ways of living and ways of working; eating: not only the kinds of food, but the regularity and quantity; drinking: limitation on alcohol; smoking: the elimination of cigarette smoking entirely—all would help immeasurably in reducing the incidence of cancers of various kinds, cardiac and vascular diseases. This would not only reduce the need for medical care and the costs of care, but would lengthen, strengthen, and make our lives more enjoyable.

We also agree that it is almost impossible to change styles of living, ways of eating, drinking, and smoking, once they are established and reaffirmed by advertising and merchandising methods. Health education has to start in infancy to incorporate these lessons into our innermost selves. Preventive services in childhood can have a great payoff, in the economic as well as the physiological sense, if education of children and their parents into better ways of living can be established.

The program models in so many European countries—Sweden, France, Finland, Holland, Denmark—that operate most successfully in the child-health area, use specially trained child health nurses. Americans are increasingly turning to nurses and physician assistants to play a part in the medical care system. There should not be too much resistance to the introduction of child-health nurses into a preventive-care system for children. For those who argue that the children will not be well-served this way, there is the Swedish evidence that nurses do as well as general practitioners in case-finding and diagnosis in their screening examinations of children, and that their findings are as correct and as complete as those of the physicians.

The British hope to convert their doctors to more interest in and concern for preventive medicine in their medical education system. Our experience over the past twenty-five years in the United States does not yield much hope that this is feasible. Prevention always seems to take second place to the excitement and challenge complicated and obscure illnesses have for medical practitioners regardless of what is taught. A fresh approach seems sensible and hopeful.

One American attitude that may be hard to change is that of considering public services as for the poor alone. Most students in the welfare and social service field are agreed that social policies aimed at the poor alone cannot succeed. European systems of child care make no distinction among socio-economic classes for eligibility. There is no justification for punishing a child by withholding preventive services because a parent is neglectful or ignorant.
Another social concept with controversial aspects is that of public financing of private agencies. Only if Americans recognize that the purpose is not to generate exclusiveness but to foster inclusiveness will this prejudice be overcome. Understanding of the Dutch approach to "verzuiling" can be most helpful.

One is reminded of the fact that sociologists now see America more as a stew pot, in which the ingredients still remain distinctly recognizable although influencing the flavor of the whole, rather than a melting pot, in which the elements have lost individual identity and become homogenized. Americans, despite some evidence to the contrary, love their children as much as citizens of other countries. The deficiencies in child care have been brought to their attention; now a model is provided as to how improvement can be accomplished. Whatever the difficulties, an American solution can be found.

Conclusion

Even a brief look at the successful models of programs for the health of children in countries that are not wealthier, indeed some of which are very much poorer, than the United States is sobering. It is obviously not lack of public investment in the area, since we are spending at least $2 billion from the federal treasury alone in health- and medical-care programs for children. What is more, the failure to acknowledge the deficiencies of the system stems from inertia more than from opposition. The children suffer. The next generation will suffer too, in diminished capability and heavy social and financial costs.

Awareness of the need for comprehensive child-care programs, active, vocal community agitation in support of such programs, and continuing advocacy of child-health services is essential. In the American political structure, without an interest group, no segment of the population can obtain recognition and legisla-

tive action. CHILDREN NEED A POWERFUL NATIONAL ADVOCACY BODY; without it, change and improvement are doubtful.

The evidence of the European experience clearly indicates the possibility of health-system modification in structure, organization, staffing, and financing to provide improved health services for our children.

Offering more health services to the poor or money to buy health services in the traditional, so-called mainstream of modern medicine, is insufficient. All children need the services and few of even the well-to-do children and families in our society are now getting all that they need and all that is available to give them if a proper system were in effect.

A Program Of Comprehensive Preventive–And Medical–Care Services For All Children Is Necessary And Is Successfully In Place In Many European Countries

The content of such a program includes preventive services that begin with the pregnant women and extend through infancy and the school years. Nutrition and health education are an integral part of the preventive services. The institutional side includes not only hospitals, but assessment centers and special health and educational care for permanently handicapped children. Physician services for sick children in the home, office, and hospital are included.

Since there are federal programs already in existence providing a variety of services of these kinds, including nutritional ones for special groups in the population, federal-program design and supervision can begin with the consolidation of responsibilities into a child-health and medical-care program.

A Separate Preventive Service For Mothers And Children Should Be Established

While liaison with the curative side would have to be maintained, a preventive service
should be funded, organized, and supervised as a separate entity. This service would include prenatal care and well-baby care; immunizations; home visiting, health education of the family and the children; social and psychological counseling; school health supervision; assessment centers for the handicapped; and medical-specialist consultations where indicated. The preventive service would have the responsibility for maintaining contact with the family, serving as the "primary care" focus and relating to other agencies—social, medical, educational and psychological—for referral and follow-up to the families under care.

A Cadre Of Child-Health Nurses Should Be Trained To Staff Centers And Agencies For the Delivery Of This Preventive Care

Since medical education, despite efforts to the contrary, pursues a scientific line of training that encourages specialization and attention to disease, it is hardly likely that prevention can be made a priority element of medical practice. Perhaps the technical expertise of the doctor should be encouraged and the area of prevention opened up to a whole new cadre of trained people: child-health nurses, on the order of the child-health visitors recommended recently for Great Britain.

This would assign a different set of responsibilities to the pediatricians now in practice and in training: the offering of supervision and a medical dimension to the planning and implementation of such a program. They could also continue to take care of sick children as the need arises and provide all hospital care.

American pluralism is hardy and unlikely to wither away. The creation of a child-health service of this kind provides an opportunity to encourage its growth. Neighborhood groups, health centers, social agencies have flourished when they had effective social roles to play. In Holland along religious lines, in Belgium along language lines, such voluntary nonprofit agencies offer analogous models. Consumer control of professional services is readily accomplished this way.

Membership In These Non-Profit Groups Would Require Payment Of Dues And The Remainder Of The Budget Would Be Supplemented By The Government Through Support From General Revenues

Since the federal standards will describe what is required and what is expected of these child-health agencies, a cost ceiling can be established and the public supplement can be used only to offset the deficit of the organizations according to that ceiling. Wealthy families will not be able to outbuy or outbid poorer ones, since salary scales would be national. While all families would be able to join whatever agency they chose, families with income below the national median would not be expected to pay anything. Financial arrangements would be open to public accounting, and publication of financial reports would assure on the part of all citizens full knowledge of the rationale of support.

Private Non-Profit Child-Health Agencies Should Be Encouraged To Undertake Management And Operation Of These Preventive Services, Recruiting Families Locally And Maintaining Local Control, Along With Public, Officially Operated Agencies For Delivering Such Services

A Medical-Care Insurance Program For All Necessary Medical Services To Children Must Be Set In Place Simultaneously

Although family support in the form of allowances to the family or to the children is probably essential to an effective long-term strategy for child-health care, the various elements of a child-health service can be put in place without these in the beginning.
Without access to medical care, families would soon lose confidence in the value of the preventive service; the workers in the preventive system would become disillusioned and cynical and the health service would fall apart.

Universal entitlement to medical care, for acute illness and for disabling and handicapping conditions, is essential to the effective working of any child care system. The comprehensive-treatment system would have to include psychological diagnostic and treatment centers as well as medical services. It would also include the midwifery aspects of care in pregnancy.

To The Extent Possible, Fee-For-Service Should Be Eliminated As The Mechanism Of Reimbursement Of Physicians And Other Professionals In The Comprehensive Child-Health And Medical-Care Program

It is not unlikely that the encroachment of the child-health nurse on the care of children for simple and uncomplicated illnesses may make it possible for the pediatricians to become wholly salaried hospital employees.

Official Agencies Would Be Responsible For Quality And Cost Control, Research Into Effectiveness And Innovation, As Well As The Usual Record-Keeping And Monitoring Of Programs

The role of the official agencies at the various levels should include monitoring; encouraging design and formation of the child-health agencies offering the services; in part maintaining records for comparison and evaluation; maintaining an inspector-general’s office to see that programs work as they are intended and that neither the patients nor the professionals are short-changed; and carrying on continuing research into the effectiveness of the programs and possibilities of improvement in design, management, quality/cost control, education and training of personnel, and health education of the clientele.

An Ombudsman, Whether Appointed From Time To Time From A Panel To Review Selected Cases Or On a Permanent Status Available For Consultation And Binding Judgments, Should Be Made An Integral Part Of The Preventive Services Program With Ties To The Health-Care System, Medical Services, Social Service Agencies, Inspector General’s Office, And The Courts

Finally, a watchdog outside the medical-care system to protect the interests of the child is a necessary component of any effective program. Both the British and Scottish health systems have mandated an “ombudsman,” and in Holland the “medical referee” plays such a role. A Child Welfare Committee in each local community, as in Scandinavia, may be another way of dealing with neglect or abuse of the child or with the inefficiencies of the medical-care program.

In summary, an approach based on traditional American principles, deriving from the experiences and examples of some European countries, is suggested for improving health services for children in the United States. Prevention is to be emphasized by the organization of a separate preventive-health service for children, parallel to and in communication with, but not administratively part of, the medical-care system. This preventive-health system would be staffed mainly by specially trained nurses, with some supervisory and consultant role for physicians. The organizational units would be locally sponsored non-profit membership agencies, both private and official, which families would be free to select from and which would be approved as capable of providing prescribed services and, therefore, be eligible to receive public matching funds.

The preventive services would include prenatal care and all preventive services required
by children from infancy through the school years, including nutrition, counselling, family-health education, and case-finding and referral for all handicapping conditions.

At the same time, through a health-insurance system, all children would be entitled to medical care in the doctor's office, at home, and in the hospital. All midwifery and obstetrical care would also be covered by this medical-care insurance.

We must provide an effective health- and medical-care system for our children. A program of universal entitlement, either as a national health insurance or a national health service, is not enough to guarantee that. We need a preventive and a curative system. To quote an old friend: It is time to give up our principles and do what is right.

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