Sound Recommendations

1. "Redefine public health as a discipline concerned with, etc." His only failure is in not using the term community instead of "individual," and his failure to say distinctive discipline," two significant and colossal omissions.

2. "The present-day curriculum of schools of public health needs drastic revision." This we have said for 20 years. "Tis true tis pitty and pitty tis tis true." The solution is hardly to make schools health action tools, even for the APHA.

3. "Our schools might well become involved more deeply in" first level public health training such as environmental health aides—health education aides, community health outreach aides, and so on." How? When action programs are categorically separate, have categorical fundings, and demand categorical training, i.e., family planning, comprehensive health planning, etc.? The solution might be equally shared by the operating and donating agency that force schools down the wrong road.

I repeat, these recommendations are remarkably sound, considering.

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To the Editor:

These comments are well taken. As those who attended the Delta Omega symposium at the Philadelphia Annual Meeting will remember, this paper was one of three given by individuals who had recently completed an M.P.H. curriculum. Questions similar to those raised by Drs. Tebbens and Tabershaw were raised for the panel, and there was an extended discussion of the concepts touched upon in the paper.

The concepts presented in that discussion—and admittedly rather poorly developed in the original paper—need to be reviewed to place the comments above in perspective. I am quite sensitive to Drs. Tebbens’ and Tabershaw’s last comment—that the frame of reference in which those remarks must be viewed is quite different now, than at the time they were delivered.

The concept of “career ladder” has received considerable attention in recent years. Basically, this idea holds that individuals who enter the health field in the lower or basic job categories should have opportunities—and needed guidance—to move to more complex occupational titles. This requires reexamination of traditional educational concepts such as rigid prerequisites, and development of inservice and supplemental training activities to permit the individual to “earn while he learns.”

Where would the school of public health (SPH) fit into a scheme to structure career ladders in public health disciplines? Not, certainly, as a “secondary vocational school.” Rather it would seem the SPH, with its long-standing and rather unique experience in preparing professional health workers could serve as the coordinator of an integrated vertical educational structure for public health careerists. This would require, I believe, the SPH to establish formal working relationships with vocational schools, community and junior colleges, baccalaureate programs, and other graduate schools in the university. Through coordinated curriculum development and sequential course offerings, this education structure could add real meaning to the career ladder concept.

The elements might function as follows:

1. Vocational School

Utilizing curricula developed by the SPH, the secondary vocational school would prepare individuals for entry level jobs in public health such as environmental aide, community health worker, health education aide, etc.
2. Community College

Aides active in the various types of programs in a community could pursue a certificate program in the community college setting. The program would emphasize basic college skills, greater understanding of their field, and administrative skills. It would qualify them for supervisory and management positions in programs using basic aides, or for other positions of greater complexity than the entry level jobs.

3. Baccalaureate Programs

Certificate holders (as well as secondary school graduates) could enlarge their skills and expand their understanding of their field through additional studies leading to a bachelor's degree. Graduates might fill existing jobs requiring this level of preparation, and might also move into the teaching field in the entry level training programs.

4. Graduate Programs

The next step on this type of ladder would be graduate study leading to an advanced professional degree or academic degree. This level would be entirely consistent with the universities' functions at the "leading edge of thought."

One could argue that all of these...
steps are already available to the would-be health careerist and that this type of program could be developed by the individual. What is lacking, in my opinion, is the integration of programs and the counseling of participants toward a career objective. Not every individual who enters at the lowest level will be motivated enough to move on up the ladder. No student who is so motivated, however, should be denied the opportunity to do so because of lack of administrative or curriculum coordination. The SPH is in a position to provide the needed leadership as an adjunct to its basic research and education functions. This, it would seem to me, is an exercise of responsibility to society on the part of one of society's institutions.

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To the Editor:

National Health Insurance and Health Services Delivery Reform—A Question of Priorities?

Both the professional journals and popular press are giving increased attention to national health insurance. Indeed, it is not unfair to say that one would be a bold prophet today to predict that the United States will not have some form of national health insurance by 1980.

The evidence to support this widely held belief is not hard to find. The alliance that successfully pushed for Medicare is again alive and active and has united behind the bill introduced by Senator Kennedy (D., Mass.) to enact national health insurance.

Other developments indicate, more-over, that national health insurance will be enacted with more speed and less conflict than Medicare. Specifically, the costs and headaches of Medicaid are creating enormous problems for the states and have led the nation's governors to advocate national health insurance as a solution to their problems. Moreover, the bitter memories of the Medicare fight have led conservative groups and even the American Medical Association, to adopt a more conciliatory position toward national health insurance. The AMA's Medicredit plan represents a marked improvement over previous AMA positions. Despite its clear inadequacy, Medicredit indicates a willingness on the part of organized medicine to compromise on the subject of national health insurance.

There is, however, new opposition to national health insurance among health system reformers who normally would be expected to support the idea. Their main argument against national health insurance is that it will—like Medicare—dramatically increase costs by increasing demand without making the changes necessary for increasing the supply of health resources. Furthermore, they contend, by appearing to solve the major problem of payment, national health insurance will divert attention and political resources from the more fundamental organizational and delivery problems of our health care system. Fearing that the organizational and delivery components typically contained in national health insurance bills will be bargained away for national health insurance, these health system reformers argue that national health insurance should be delayed until necessary and vital organizational and delivery reforms are made in our health care system.

All health system reformers, of course, do not accept this negative view of national health insurance. First of all, there are those like Rashi Fein who concede that national health insurance may well