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A REVIEW OF *HEALTH: UNITED STATES, 1975**

ABSTRACT. *Health: United States, 1975* is reviewed with emphasis on its strengths, weaknesses and prospects for further editions.

I. BACKGROUND: HISTORY AND SIGNIFICANCE

The Health Services Research, Health Statistics, and Medical Libraries Act of 1974 requires that

> The Secretary (of H.E.W.), acting through the National Center for Health Services Research and the National Center for Health Statistics, shall assemble and submit to the President and the Congress not later than September 1 of each year a report on the Nation's Health (Feldman and Wilson, 1976).

To meet this requirement, work began on a report early in 1975; it was completed in 1976 and issued later that year. The published report – *Health: United States, 1975* (U.S. National Center for Health Statistics, 1976) – is the subject of the present discussion, but comments will also be made on a second report – *Health: United States, 1976–1977* (U.S. National Center for Health Statistics, 1977) – which to MS. writing had not yet been published. (The author had access to the MS prior to publication – Ed.)

The legislation specified the content of the report to include four major areas – health costs and finances, resources, use of services, and health status – in terms of four population characteristics – age, sex, income, and geographic area – as follows:

> A. Health care costs and health finances including trends in health care prices and costs, the sources of payments for health care services, and Federal, State and local governmental expenditures for health services.
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> B. Health resources, including description and analysis by geographic area of physicians, dentists, nurses, and other health professionals by specialty and other health professionals by specialty and type of practice, and the supply of services by hospitals, extended care facilities, home health agencies and other health institutions.
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> C. The utilization of health resources, including description and analysis of age, sex, income and geographic area of the utilization of ambulatory health services, by specialties and type of practice of the health professionals providing such services, and services of hospitals, extended care facilities, home health agencies and other institutions.
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> D. The health of the Nation's people, including a description and analysis by age, sex, income and geographic area of the extent and nature of illness and disability of the

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population of the United States (or of any groupings of the people included in the population), life expectancy, the incidence of various acute and chronic illnesses and infant and maternal morbidity and mortality. (Feldman and Wilson, 1976; wording modified to delete legislative terms.)

The third and fourth areas – utilization and health status – were combined in the report into one section.

Primary responsibility for the report was assigned to the U.S. National Center for Health Statistics (NCHS), but its financial section was contributed by the U.S. National Center for Health Services Research (NCHSR), and other Federal agencies contributed various other materials. Perhaps because NCHS had primary responsibility, the section dealing with utilization and health status is far larger than the rest, accounting for about three-fourths of the total, i.e., circa 450 of the report's 600 pages.

Although this report is by no means the first of its *genre* to be issued by NCHS and/or its predecessor agencies – many were issued prior to the present legislation – it is easily the most comprehensive, covering many more content areas, and these in much greater detail, than earlier versions. The expansion represented by the present report may have occurred because government in recent years has assumed ever wider responsibility for the economic and social well-being and the health of its citizenry, and this in turn has been a factor in the emergence of the 'social indicators movement', of which the present report may be considered a part.

Because the origin of this report lies in these earlier versions of an annual report on the Nation's health, it is understandably subject to some of the same problems and difficulties as those which plagued its predecessors. Also, because it may be thought of as part of the social indicators' movement, again it has many of the problems and difficulties of the social indicators' reports. The report's shortcomings, from the present reviewer's point of view, will be enumerated and discussed in the final section of this paper, and suggestions will be made for dealing with them in future reports on the Nation's health.

II. DESCRIPTION OF THE REPORT

A. *Conceptual Issues and Decisions*

In preparing the report, even though its content was specified in fairly considerable detail by the legislation, decisions were made on several major conceptual issues, especially in its utilization and health status sections:

1. *Primary focus*. This might have been a specific health topic (mortality, disability, heart disease, cancer, mental illness, dental morbidity, etc.); the source of data; any of the four demographic variables specified in the legislation (age, sex, income, and geographic area); any other demographic or social characteristic of the U.S. population (race, ethnic origin or cultural identity, socio-economic status, etc.); or others. Age was used as the major focus since,

> ...age is the one variable most highly related to most health topics. In addition this approach uses the person as the major focal point rather than a more abstract demographic variable or disparate health topics. (Feldman and Wilson, 1976.)

The age-categories used were, necessarily, fairly broad, i.e., under 18 (infants, children and youth), 18–64 (adults of working age), and 65 and over (adults past working age and the elderly). Since the tables were based on existing data, many could not be fitted precisely into these categories.

2. *The balance between descriptive and analytic*. Largely because of time and staff limitations, and at variance with the 'preferences', under ideal conditions, of the professional staff, the report is basically descriptive rather than analytic. For these reasons also, it uses existing data rather than the special tabulations preferable for analysis, and it contains no discussion at all of the policy implications of its data.

3. *Separate indicators versus an index*. No single, widely-accepted index or other summary or aggregate measure of health status exists as yet, and it was obviously not feasible to develop one merely for the present report. However, this decision leaves the reader in the dark as to just where this nation does stand in health status, and the consequence is that we have no benchmark against which to assess our present situation nor to use for comparison purposes in future reports, although this may in fact have been the primary purpose of the present compilation. However, this is not to be taken as a criticism of the present report nor of the professional staff compiling it. This problem plagues the health field in general, and much of social science as well, and it makes us at one with other measurement efforts in the social sciences, e.g., of socio-economic status and/or social class, of intelligence, of the quality of life, and of other social and psychological indicators. This topic too will be discussed in the final section of the paper.

B. *Topics Covered*

As indicated previously, four major content areas were included in the report: health costs and finances, resources, use of services, and health status (the latter two combined for presentation).

1. The first content area, health costs and finances, appears as Section A, *Financial Aspects of the Nation's Health Care*. It presents data in three sub-sections on national health expenditure trends, the sources of funds for health expenditures, and their allocation by type of medical care provider. Section A overall accounts for about 100 of the report's approximately 600 pages, about one-sixth of the total. Each sub-section of Section A covers a variety of interesting topics whose presence might not be guessed from the sub-section's title. For example, the allocation of expenditures includes data on medical care prices, physicians and dentists' incomes, and others.

2. Next, under resources, Section B *Health Resources* contains two sub-sections, health manpower and health facilities. This section is shorter, slightly fewer than 50 pages, but it too provides a variety of interesting data.

3. Finally combined SEctions C and D, *Health Status and Use of Health Services*, comprises by far the longest section of the report, clearly of greatest importance to the compilers. It first presents data for persons of all ages, followed by separate sub-sections for ages under 18, 18–64, and 65 and over. The all-ages sub-section covers eight topics: (1) Population and population change; (2) Fertility; (3) Mortality; (4) Measures of health, illness, and disability; (5) Reported communicable deseases; (6) Preventive care; (7) Ambulatory care; (8) Inpatient utilization, short and long-term care. Each sub-section pertaining to an age-group covers three topics; (1) Mortality and measures of health, illness, and disability; (2) Utilization of services; and (3) Dental morbidity and dental care. Clearly the wide variety of topics for all ages and even for each age-group precludes more than the most cursory look at each topic.

III. CHANGES IN THE NEW EDITION: HEALTH, UNITED STATES, 1976–77

A major innovation in the 1976–77 edition is the inclusion as Part A of analytic papers on selected health topics. To my knowledge four such papers were included: (1) The condition of health and health care; (2) Hypertension; (3) Health insurance; and (4) The elderly population. Other innovations are

the inclusion of a glossary of terms and a report on sources of data. Part B, *Data on the Nation's Health*, follows the 1975 report even to format, disaggregating however the sections on health status (now called health status and determinants) and utilization of health services. Also, many of the earlier tables are not repeated while many new tables are added. These new tables cover a much wider variety of topics than the 1975 report, e.g., on hazard index scores of consumer products, alcoholism, drug abuse, persons exercising regularly, etc. Time and space limitations preclude a more extended listing and any discussion.

IV. WHAT THE 1975 REPORT SHOWED

What was the state of the nation's health in 1975? The report does not present any overall summary, and clearly any attempt at it must be considered at best very nearly an exercise in futility. Nevertheless, highlights are in order.

Under expenditures, the United States spent approximately $99 billion for health and medical care in 1973 (the latest data shown in the report), 7.7 percent of GNP. The annual rate of growth was rapid during the late 1960s (12.2 percent), but slowed to 10.4 percent after 1971. The proportion of GNP spent on health and medical care rose steadily from 1929 through 1971, levelling off at 7.7 percent since then. Price increases accounted for about one-half of the rise in expenditures 1965–71, less since then largely because of the Economic Stabilization Program. A major shift has occurred in sources of funds for health expenditures, from private to public, for both total and personal health expenditures. Within private, health insurance coverage has expanded, especially for hospital care, and hospital care now absorbs 39 percent of the medical care dollar, a steady rise since 1929.

Under resources, the manpower employed in health-related occupations numbered an estimated 4.4 million persons in 1973, one-half of whom were in nursing or related services. Each physician served 562 persons in the U.S.; the number of physicians has been growing more rapidly than the population in recent years, the ratio thus becoming more favorable. At the same time the proportion of the country's physicians foreign-trained has increased, to 19.5 percent in 1973. The geographic distribution of physicians, especially specialists, is weighted heavily toward metropolitan areas, especially the larger areas. Despite a decline in general practitioners during the past decade, compensating

increases have occurred in other specialities providing primary care (internists, pediatricians, obstetrician-gynecologists).

Still under resources, health facilities overall have increased in recent years, non-Federal general medical and surgical beds now numbering 4.3 per 1000 resident civilian population, up from 3.4 in 1948 when the Hill-Burton program began. The distribution of beds over the country has become more nearly balanced. Within recent years the shift has been from construction and expansion to modernization of existing facilities. While non-Federal short-term beds have increased, Federal and non-Federal psychiatric and tuberculosis beds have decreased. The provision of special care in hospitals has increased, especially open-heart surgery, radioisotope, and renal dialysis units. Nursing home beds more than doubled from 1963 to 1 328 000 in 1973. Other residential health facilities contain an additional 451 000 beds; these are mostly in facilities for the mentally retarded, the emotionally disturbed, orphans and dependent children, alcohol and drug abusers, and the physically handicapped.

Finally, under health status and use of health services, mortality rates and life expectancy have improved greatly in this country since 1900, overall and for both males and females and whites and non-whites alike. Mortality rates reached a plateau in the late 1950s, but resumed the decline in the late 1960s. Mortality is inversely related to education and is lower in metropolitan areas without central cities (suburbs) than in either metropolitan areas with central cities or non-metropolitan counties.

Infant mortality fluctuated in the United States from the mid-1950s to the mid-1960s, declining only slightly, but since then the drop has averaged four percent annually. The infant mortality rate for minority infants is two-thirds again as high as that for white infants. During the last decade the rate for minority infants has declined somewhat more rapidly than for white, thus narrowing the gap between the two; however, this follows a widening during the preceding 15 years. Available data do not permit determination of whether the currently existing socio-economic differential in infant mortality has been widening or narrowing during the past decade.

Mortality rates during early childhood have declined more since 1900 than those for any other age group; at ages 1–4 the drop has been by 95 percent. At ages 15–44 death rates decreased for tuberculosis, heart disease, and influenza and pneumonia but deaths from external causes – accidents, suicides, homicides – have increased rapidly among younger adults since mid-century.

At ages 45–64 chronic diseases increase as principal causes of mortality (as

well as of morbidity), becoming more important than external causes. Diseases of the heart are by far the leading cause of death and inpatient hospitalization and result in more long-term limitation of activity than any other condition. Despite the decline in death rates from heart conditions in recent years, they remain a major health problem. Also at 45–64, death rates from most other major diseases have also decreased during the past 25 years, especially from strokes, arteriosclerosis, kidney diseases, and gastric ulcer. Malignant neoplasms, especially of the respiratory system, constitute a notable exception to this trend. At ages 45–64, death rates are low relative to rates in the older age groups, but high relative to many European countries, primarily due to high rates for heart disease and other cardiovascular conditions, malignant neoplasms, and cerebro-vascular conditions (stroke).

Death rates are high at 65 and over; on average, persons reaching 65 can expect to live another 15 years (13 for males, 17 females). Because the mortality rate for males is higher at every age than for females, the aged population consists predominantly of females; thus there are only 70 males per 100 females at 65 and over and 50 at 85 and over.

Most babies born in the U.S. today are relatively well off, even prior to birth; thus about 70 percent of their mothers initiate prenatal care during the first three months of pregnancy, with 99 percent of the babies born in hospitals. In 1940 slightly over one-half of all births occurred in hospitals. The frequency of medical problems during pregnancy and delivery underscore the importance of having adequate prenatal care and hospital facilities available. Thus among mothers of legitimate live births in 1972, about 16 percent were reported by the hospital to have one or more complications of pregnancy and about 20 percent one or more complications of labor. These rates are higher for illegitimate births and for births among the poor and nonwhites.

At ages 1–14 the terrible formerly epidemic diseases – cholera, plague, typhus, yellow fever, smallpox – have virtually disappeared in this country, but even tuberculosis, diphtheria, poliomyelitis, and measles have been reduced to phenomenally low levels. Mortality and morbidity from influenza and pneumonia, as well as from accidents, although greatly reduced, still represent important problems. Accidents to young people are a serious cause of permanent impairments. Although the health of children has improved greatly, many still have severe health and developmental problems, e.g., faulty vision and dental morbidity, to mention merely two.

At ages 15–44 disability from chronic diseases – hypertension, heart disease, osteoarthritis – become increasingly important. At these ages also, venereal disease, once again epidemic after a period of decline, represents an important health problem. Obesity, too, generally begins at these ages. Utilization rates of both inpatient and outpatient psychiatric facilities are higher at 18–44 than at any other age.

At ages 45–64 heart problems become a major cause of disability, causing activity limitation among 1.5 million of the 43 million people in this age-group. This cause of disability is followed by arthritis (1.3 million), impairments of the lower limbs or hips (620 000), hypertension (420 000), and diabetes (400 000). In all, 8 million adults in their middle years report chronic activity limitation. The toll of disability from acute conditions adds to this.

All of these figures become much higher among the elderly, 65 and over. Approximately 3.4 million – about 18 percent of the aged non-institutionalized population – are limited in mobility to some degree, about 3.2 million unable to work or do housework. About 8.6 million reported some degree of activity limitation because of chronic conditions, approximately 17 percent because of heart disease, and an additional 16 percent arthritis. About one million people – 5 percent of the elderly population – reside in nursing homes, and 72 percent of these are women. Nearly all have multiple chronic conditions, averaging three per person. About 23 percent have arteriosclerosis, 11 percent suffer the after-effects of strokes and 14 percent are senile, while 10 percent have mental disorders.

V. CONCLUSION

It is this reviewer's judgment that, on balance, *Health: United States, 1975* represents an enormously useful, even if dis-aggregated, summary of where we stand in health, an extremely complex topic. The framers of the original legislation requiring the report and the professional staff compiling it are both to be commended.

While recognizing that my preferences are not those of the field generally, and that their implementation may not be feasible, I would nevertheless like to indicate what I think should be done. I would incorporate a broader definition of health than the one which, although nowhere explicitly defined, was, nevertheless, implicit in the report. From my perspective, health status should

be defined to include social well-being as a dimension of health status. Social well-being, in turn, I define as including the level of material well-being; adequacy of major role performance; quality of participation in primary groups, such as the family, providing social support; quality of participation in secondary groups (the obverse of social isolation from one's community); and assessment of the individual's moral worth, both by oneself and by others. Each has a perceptual dimension through which the objective reality is funneled; this makes it more difficult to measure, but it in no way detracts from the importance of measuring it.

The obverse of social well-being is, of course, social pathology; the report contains some data on alcoholism, but drug abuse is not mentioned. Also not mentioned are unemployment, poverty, and crime. Finally, along these same lines, more emphasis should have been placed on mental retardation and emotional disturbance.

How justify the inclusion of material on health expenditures, resources, and use of health services? If these are included as factors affecting the health level of the population, should not data on non-health services' factors be included as well? In this reviewer's judgment, indeed they should! Tables should have been presented on air and water pollution, on radiation, on life styles, and on various aspects of health education and knowledge. The consequences of ill health – e.g., orphanhood, dependency ratios, tables of working life, and others – should also be here.

Finally, as a suggested procedure for the future, both the major strengths and the weaknesses of the health level of our population, and the factors affecting it, should have been cast into bolder relief; i.e., perhaps a section could be included to deal with the major plusses and minuses of where we stand. This might have been derived by convening a panel of experts to set normative standards. Although there would surely be difficulty in arriving at a consensus, these experts could tell us where we ought to be, as opposed to where we are, in relation to the effort expended to get there. Granted the difficulties, and the dangers, in this procedure, it might greatly improve the usefulness of the present report to both policymakers and the concerned public.

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NOTE

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