

PROPOSAL TO DEVELOP LEGISLATION  
ENABLING THE ESTABLISHMENT OF A NATIONAL HEALTH CORPS  
IN THE U. S. PUBLIC HEALTH SERVICE  
Laurence J. Platt, M. D.

A. PROBLEM.

As long as there are people in this country who are denied essential health services because of poverty, or race, or lack of access for any reason, we have fallen short of our promise as a Nation...

- White House Report on Health Care Needs,  
July 10, 1969.

A promise has been declared. Yet large segments of our population continue to be denied access to vital health services -

.approximately two million people currently receive no medical care whatsoever;

.about twenty million people receive only some part of the care they need;

.an additional twenty million who live in the ghettos receive less than adequate care. 1/

Congress has in recent years created dozens of Federal programs to support development of delivery systems, encourage training of health manpower, construct facilities, and stimulate health planning.

Still, none of these Federal programs provides for a prior essential - staffing - without which public health services for the deprived millions will remain an unfulfilled promise. The essential of staffing is an expression not only of numbers, but also of distribution and deployment of health manpower.

Thus, given an efficient, high-quality program of delivering adequate health services where none, or almost none, had been available before, the problem of staffing would still remain--a problem that even greatly expanded training programs would not help. For communities that were previously unattractive to health personnel, are not necessarily made more attractive by the mere construction of new facilities, or by increased community involvement, or by mechanisms for efficient care, or even by noble ideals.

Medical journals, for example, are filled with advertisements urging physicians, nurses, and other health personnel to come and occupy a building that has been newly constructed by a community. Too often the facility remains empty. As seen in table 1, a progressive decline in number of physicians per 100,000 population is evident as one moves farther away from the cities. Even greater is the decline in "general specialists," i.e., internists, pediatricians, obstetricians, and general surgeons.

The same picture of personnel distribution is seen with regard to dentists, nurses, and, to a lesser extent, other health technicians (see table 2).

The provision of accessible health services of adequate quality to rural areas--where the economic base might be poor, or where professional and cultural isolation might exist, or where health professionals are notoriously over-worked--is, to a large extent, a problem of staffing.

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TABLE I  
DISTRIBUTION OF NON-FEDERAL PHYSICIANS  
AND POPULATION BY COUNTY GROUPS, AS OF 12/31/65

(Based on data from AMA, Distribution of Physicians  
Hospitals, and Hospital Beds in the U.S., 1966)

	<u>Total U.S.</u>		<u>Greater Metrop.</u> <sup>1/</sup>		<u>Lesser Metrop.</u> <sup>2/</sup>		<u>Adjacent</u> <sup>3/</sup>		<u>Total urban</u> <sup>4/</sup>		<u>Isolated semi-rural</u> <sup>5/</sup>		<u>Isolated rural</u> <sup>6/</sup>		<u>Total rural</u> <sup>7/</sup>	
	Number	No./ 100, 000 pop.	Number	No./ 100, 000 pop.	Number	No./ 100, 000 pop.	Number	No./ 100, 000 pop.	Number	No./ 100, 000 pop.	Number	No./ 100, 000 pop.	Number	No./ 100, 000 pop.	Number	No./ 100, 000 pop.
Population	190,000,000		69,000,000		59,000,000		30,000,000		160,000,000		29,000,000		6,000,000		35,000,000	
Total phys.	270,000	140	130,000	190	81,000	140	25,000	83	240,000	150	25,000	86	3,000	50	28,000	80
Total in priv. prac.	180,000	95	82,000	120	56,000	95	20,000	67	160,000	100	20,000	69	2,600	43	23,000	66
Gen prac.	65,000	34	24,000	35	17,000	29	11,000	37	52,000	33	10,000	34	2,300	38	12,000	34
Gen surg.	18,000	9.5	7,600	11	5,800	9.8	1,900	6.3	15,000	9.4	2,100	7.2	130	2.2	2,200	6.3
Int. med.	22,000	12	12,000	17	6,900	12	1,600	5.3	21,000	13	1,700	5.9	68	1.1	1,800	5.1
Ob-gyn.	12,000	6.3	6,200	9.0	4,300	7.3	1,000	3.3	11,000	6.9	970	3.3	26	0.43	1,000	2.9
Peds.	9,600	5.1	4,700	6.8	3,300	5.6	750	2.5	8,700	5.4	790	2.7	18	0.30	810	2.3
Psych.	8,100	4.3	5,500	8.0	2,000	3.4	310	1.0	7,800	4.9	280	.97	12	.20	290	.83

1/ 109 counties in SMSA's with 1 million or more inhabitants.

2/ 301 counties in SMSA's with 50,000 to 1 million inhabitants.

3/ 889 counties contiguous to metropolitan areas. Population in such counties ranges from 500 to 508,500 inhabitants.

4/ Sum of first three groups.

5/ 1,024 counties containing at least 1 incorporated place with 2,500 or more inhabitants.

6/ 758 counties not included in the above 4 groups.

7/ Total of isolated semirural and rural.

Table 2 - Selected categories of active health personnel per 100,000 population, by geographic division: various dates

Geographic division	Physicians M.D. <u>1</u> / 1965	Dentists <u>1</u> / 1965	Nurses- R.N. 1962	In hospital, 1966	
				Practical nurses	Aides, orderlies
United States ...	132	45	298	79	258
New England.....	168	53	470	97	261
Middle Atlantic.....	171	58	376	81	286
South Atlantic.....	116	32	255	70	228
East South Central.....	89	31	165	78	210
West South Central.....	101	31	171	99	207
East North Central.....	120	45	286	68	269
West North Central.....	114	47	301	72	299
Mountain.....	115	43	307	78	223
Pacific.....	157	53	329	70	229

1/ Non-Federal per 100,000 civilian population.

Source: A.M.A. Directory Report Service, vol. 17, supplement No. 47, Chicago, American Medical Association, Jan. 3, 1966.

"Health Resources Statistics: Health Manpower, 1965." Public Health Service Pub. No. 1509, Washington, U. S. Government Printing Office, 1966, 182 pp.

"The Nation's Nurses. The 1962 Inventory of Professional Registered Nurses." American Nurses' Association, 1965, 39 pp.

Unpublished material based on P.H.S.-A.H.A. survey of hospital manpower.

Even in metropolitan areas, where the physician-nurses- and dentists-to-population ratio is higher, there exists a staffing maldistribution within the city. Thus, Neighborhood Health Centers have been established in poverty areas with systems providing for community involvement, for comprehensive care, for

training and utilization of allied health workers, etc., only to run into problems of staffing 2/ 3/. Indeed, the AMA's Committee on Health Care of the Poor was requested by OEO officials to consider sending a health care team to serve for two-month tours as technical assistants in the OEO centers, along the lines of the AMA's Volunteer Physicians for Vietnam.

Clearly, to fulfill the promise of making health care accessible to everyone, a mechanism for providing health personnel to those populations at a geographic or economic "disadvantage" must be established.

B. MECHANISM FOR DEALING WITH PROBLEM.

To deal with the problem of maldistribution of health personnel, a number of countries, e.g., Norway and Mexico, require health professionals to serve in areas otherwise wanting in personnel as part of qualification for practice. It is suggested that the United States develop a similar program suited to this country's needs, systems and social philosophy.

Accordingly, it is proposed that a National Health Corps be established as part of the United States Public Health Service with the following overall goals:

1. to provide health personnel in accordance with Regional and State Health Plans; and in accordance with guidelines and priorities established

by the Public Health Service to communities (consumer groups, local governments, planning agencies, and/or voluntary health agencies representing the communities) making application for staffing and/or technical assistance.

2. to provide health personnel in such a way as to promote efficient, continuous, high-quality health care suited and responsive to community needs;
3. to develop a system that facilitates eventual voluntary staffing of the community's facility where possible.

To these ends, the following mechanisms are proffered:

- (1) The establishment of a National Health Corps made up of enlisted physicians, nurses, dentists, pharmacists, podiatrists, optometrists, physical and occupational therapists, health administrators, lawyers, medical social workers, laboratory workers, and other health personnel.
  - a. physicians - Approximately 1,500 physicians enlisting in the NHC under the Commissioned Officers Residency Deferment (CORD) program would serve, in fulfillment of their military obligation, a 25 or 37-month tour of duty with real pay and privileges commensurate with that offered by the Armed Services; both male and female physicians would receive equal consideration and have equal obligations.

That the enlistment be conducted through the CORD program is preferred because it would ensure (a) a maximum amount of training and experience consistent with the goals of high-quality care and of provision of service to the community rather than of training for the physician; and (b) the availability of the physician for prolonged service (in or out of the Corps) to the community, should he decide to stay, without necessity of interruption of his service for additional training and possible consequent loss of interest in the community, as well as his continuity of service.

That the enlistment be for 25 months is suggested with the following scheme in mind. For the first 12 months of duty, the physician would pick up the practice of a departing officer, as well as pick up new patients of his own. During the second 12 months he would be physician only to those patients he had accumulated during his first year. The 25th month would be spent in

orienting the officer taking over his practice to the patients (and vice-versa), to particular problems of families, to the community, and to the practice itself. Besides working as a mechanism for continuity and meaningful transition, the 25th month would also tend to discourage entrance to the service before completion of training, since most training programs begin on July 1. (It would also require a desirable commitment on the part of physicians to this type of service since it calls for 1 month more than is required in the Armed Services.)

An alternative to the proposal that physicians serve a 25-month tour of duty is service for a 37-month tour of duty. The primary advantage of a longer tour is its contribution to continuity of care. In addition, it would require a greater commitment on the part of the health officer to the goals and purposes of the NHC and the communities it would serve. It might also counteract certain enticement advantages of the NHC vis-a-vis the military services, such as domestic duty, closeness to family, and less personal risk.

The extra month (the thirty-seventh) is suggested for reasons similar to those suggested for the twenty-fifth month; i.e., better transition from one medical officer to another and encouragement of completing training prior to service.

Under the 37-month proposal, an officer would accumulate patients only during his first 18-24 months, and orient the new physician during the 37th month.

That the service be open to female physicians is not only non-prejudicial but equitable as far as the physician population is concerned. It also allows for increasing the available pool of physicians. This concept has been supported by the Student American Medical Association. 4/

- b. other health personnel - Approximately 3,500 allied personnel enlisting in the NHC would serve a 24-month tour of duty, in fulfillment of their military obligation, with real pay and privileges (according to ranks) commensurate with that offered by the Armed Services; both male and female personnel would receive equal consideration and compensation and have equal obligations.

Enlisted personnel would receive training, as necessary, for performance of their duties. Rank and promotion would be based on training outside the service for which deferment would be offered, as well as training, experience and aptitude within the

service. Thus, there would be mechanisms for vertical mobility within the service, with appropriate training and examination for equivalency programs and state licensing, where possible; for example a high school graduate entering as a nurse's aide might, as his qualifications indicated, become a nurse-equivalent; or, an assistant medical technician might become a licensed technician. As far as possible, the training programs would be conducted near or in the participating facility, so that they could include orientation to the community and its special problems.

Furthermore, assignment of the corpsman would be to his own or a similar community, as far as possible. Aside from the obvious advantages of maintenance of the family unit, economy of travel and existing housing, this would enable the corpsman to bring with him maximum amount of knowledge of the community and promote trust, confidence, and voice from the community.

It should be emphasized that deferments, ranks, promotions, etc. would operate as a personnel function of providing health service according to the general goals outlined above, and not as a function derived from the armed service's operations and goals.

(2) The establishment of a National Health Corps Executive Council, with responsibility for personnel, planning, evaluative, legal and legislative, and coordinative functions and policies of the NHC.

- a. Personnel - Included in personnel responsibilities would be recruitment, establishment of standards of hiring, promotion, and discharge, and identification of needs of particular types of health personnel to fulfill the duties and obligations of the NHC. Guidelines for staffing community health services and facilities would have to be developed, with the resource needs of a particular community in mind. Furthermore, mechanisms for review of changes in those needs would have to be developed. Ideally, identification and review of personnel needs would be carried out in coordination with the Regional and State Planning Agency involved.



Mechanisms for recruitment of interested local physicians, nurses, etc., to serve either in training or service programs in their community would also be developed; it should be emphasized, however, that corpsman would serve and be responsible to the community and not particular health professionals.

Programs to relate qualifications of corpsmen to state and national licensing systems would also be among the personnel functions of the Council.

- b. Planning - The major planning function of the Council would be development of mechanisms and priorities for selection of communities to be served. Included should be consideration of general policies established by the Office of Health and Scientific Affairs. Thus, a community's application should be considered in terms that include but go beyond relative needs. For example, a community's plan should provide for necessary facilities, for group practice, for data collection, for training programs (including, where possible, affiliations with health training institutions), for financing mechanisms and for eventual assumption of responsibility for staffing and running of the facility as much as is possible. The community should, therefore, demonstrate willingness to hire satisfactory personnel upon completion of service should a corpsman wish to stay and to offer reasonable compensation for services. For this and other purposes a local administrative office would be set up on a non-profit basis and staffed by the community with consultation as necessary with appropriate sources, including the Planning staff of the NHC Executive Council. This local community agency would run the program, including development of a financing and collection mechanism. Any profit derived from the health service would go toward (1) payment of any debts incurred in the establishment of the facility, (2) funds for future development and procurement, or (3) returned to the government to be applied against future budgetary allotment.

- c. Evaluation-data collection - The Council would be responsible for collection of data necessary for review and evaluation of the programs, individually and collectively. Attempts to isolate variables promoting efficiency or quality of given health care systems would be made and application of principles thereby derived would be instituted where possible.
- d. Legal and legislative - The Council would be responsible for insuring that plans were consistent with existing laws, state and federal, and work towards helping change the plan or laws, as indicated, as was consistent with NHC policies.
- e. Coordination - The Council's coordinative functions would include providing liaison between the Corps itself and the Surgeon General's office, the Health Secretary's office, other PHS (federal and regional) HEW offices, the Selective Service System, and the public.

(3) The revision of personnel policies of the USPHS insofar as is necessary to establish the National Health Corps.

This would include mechanisms for enlisting non-commissioned officers; for reviewing and phasing out job functions no longer commensurate with the health needs and priorities of the nation, or the policies, programs, and purposes of the PHS; contracting with non-federally employed health personnel or organizations where available and where practicable to provide services now performed by the PHS; and inclusion of the services provided under individual programs to select populations in the National Health Corps program. The latter is suggested since these services are totally compatible with the goals of the National Health Corps and exist now as isolated categorical examples of the proposed NHC functions. That is, instead of providing such services by category of population, the

Corps would provide them by relative needs of population groups (including Indians, prisoners, seamen, farmers, the poor, etc.), identified as communities rather than as professions, race, etc.

Revision of personnel policies should also include critical examination of overall policies of the PHS. It is, for example, important that a NHC be part of a system that functions as a health service; not as a health analogy to the military services; a system that recognizes relating to communities as more important than uniforms; a system in which flexibility is more important than discipline.

#### C. JUSTIFICATION FOR SERVICE FULFILLMENT OF MILITARY OBLIGATION.

Enlistment in the National Health Corps would require individuals to spend two or more years in communities where qualified health personnel would not otherwise wish to go. That a mechanism for appropriating personnel to these areas is required is implicit in the obligation this country has assumed in promising the availability of health services to all citizens. To ask an individual to provide service to the country in fulfillment of one of its obligations should not be compounded by requesting further service to the country in fulfillment of its other obligations, including that of national defense.

This assumes that the country's obligation to promoting health is at least equal in importance to that of providing for national defense. It also assumes that the country's obligations to promoting health are not being met by non-governmental mechanisms. And, finally, it assumes that the Selective Service System by

precedent and by design does and should provide manpower for purposes other than national defense.

Some propositions relative to justification of the first two of the above assumptions were put forth in 1965 by Robert H. Felix, Dean of the St. Louis University School of Medicine. 5/

1. It is the duty of government to assist its citizens to secure and enjoy those rights to which they are entitled in a free society, but which they cannot procure and possess unaided.
2. Health is a right. Insofar as it can be preserved or restored, the citizen is entitled to its preservation or restoration under the ground rules laid down above. So much of what is known of the cause and nature of illness and so many of the professionals prepared to serve the people are the result of funds invested in research and training by the people through their government that the benefits to be derived can be considered public domain, for the funds were appropriated in the first place because their expenditure was in the public interest. This means that just as a citizen can demand protection from assaults on person and property by individuals he can demand protection against assaults by disease agents.
3. A state of health is in the public interest, since a healthy population is, all things being in proportion, a vigorous, creative, and dynamic population. Therefore, for its own sake, it is important that a government assure the healthiest possible citizenry.

Further rationale for providing manpower resources to selected areas through government procurement was stated in 1952 by the President's Commission on the Health Needs of the Nation: 6/

It is now abundantly clear that the provision of adequate health services profoundly affects the individual's chances of survival and the strength and happiness of the nation as well. This fact

imposes certain ethical and practical considerations upon us. Where the very life of a man, or the lives of his family, may depend upon his receiving adequate medical care, society must make every effort to provide them. When this man knows that such health boons exist, available to some and denied to him, a free society will find the way to comply with the demand he will surely make. These benefits can sometimes be obtained by the individual's own effort, but when these efforts fail, other means must be found. And democracy requires the same high quality of service be made available for all men equally.

That the Public Health Service should be responsible for providing health manpower where it is needed is implied in a general recommendation by the National Advisory Health Council.<sup>7/</sup> The Council proposed that the PHS exercise leadership in evaluating the medical care available and identify and seek means of filling deficiencies.

In discussing justification of fulfillment of military obligation by service in the NHC, it is imperative to mention the recommendation by the National Advisory Commission on Health Manpower that "service with the U. S. Public Health Service be phased out as a substitute for the military obligation of health professionals." <sup>8/</sup> However, it is equally important to stress that this recommendation was modified by stating there should be no alternative to military service for health professionals "while such options are denied to other draft-eligible men."

Until national policies are changed to allow substitute service for all those who are draft-eligible, this choice should not be available to health professionals."

Since the NHC would be open to all health personnel and to anyone desiring training and service in health careers, the NHC would satisfy the Commission's recommendation, as modified.\*

The final assumption mentioned above that the Selective Service presently provides for health manpower for non-defense purposes is borne out by services provided to Indians, prisoners, seamen, military dependents, retired military personnel, as well as by research activity and so on. That this provision is justified is supported by the rationales offered to establish the validity of the first two assumptions mentioned above.

D. FURTHER ADVANTAGES OF A NATIONAL HEALTH CORPS.

In addition to providing a mechanism for dealing with the problem of maldistribution of health personnel, the NHC would have additional benefits to the corpsman, to the community, and to the nation.

First, it would provide educational benefits to the physician and to the other health workers.

For the physician, the NHC would afford exposure to a prepaid group practice and to community problems. The service in which the corpsman would function would be organized as a group practice. Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific

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\* It should be noted that the recommendation itself was described in the Commission's report as "emotional" by F. A. Beirne, a member of the Commission, who stated further that, "Inducement for competent doctors to work in the public interest is necessary and desirable."

Affairs, in discussing the reasons why prepaid group practice has not developed as much as it should, points out that "the potential of this type of practice for the physician, of its many, many advantages to him has not been adequately 'sold' in medical schools or in colleges or even in high schools where the young are exploring the possibilities for their life's work. Accordingly, there has been a shortage of physicians in these groups that has retarded the rate of increase." 9/

Practical experience in and familiarity with prepaid group practice would be one means of "selling" group practice to physicians. Such experience has been suggested by the Citizens Commission on Graduate Medical Education in a report commissioned by the AMA (the Millis Report). 10/

Service in the NHC would also increase physician awareness of community problems and their relationship to health and disease. More and more statements are being made regarding the necessity of a physician relating to a patient within the context of social and cultural relationships. The fact that these statements are being made indicates that while the good physician has always understood this necessity, society can no longer afford the luxury of leaving perpetration of this insight to chance. 11/ 12/ The communities to be served by the NHC would, by and large, have deficiencies and problems other than health personnel. In performance of his service and through orientation

programs, the physician in the NHC would become aware of the results of these problems in terms of health and would be encouraged to deal with them both as problems themselves and, specifically, as contributors to disease processes.

Another fundamental benefit of an NHC would be exposure of the physician to modern concepts of medical care - the "team" approach to health services; the use of allied health personnel, including workers in categories just now being developed; the problems and satisfactions of family practice; the practical meaning of continuity and comprehensiveness of care; prepayment programs, and salary reimbursement; the role and benefits of health planning.

The NHC would also provide education for other health personnel, both the areas of awareness described above and also specific health skills training. The concept of vertical mobility is an important one, and one, unfortunately, all too rare in the health field. Furthermore, training in health fields would prepare the individual for a job in a market relatively starved for personnel.

The advantages to the community go beyond the obvious one of availability of health services. By exposing health personnel to the community, the Corps would also be exposing the community to the health corps and perhaps, thereby, to itself. It might become more aware of its needs and, consequently, to required



solutions. It would certainly become aware of health organization, including, for example, prepaid group practice and the advantages thereof.

The benefits to the Nation, other than the indirect benefits of a healthier population, would include provision of a data pool for research in health services, and further fulfillment of its social and health obligations and provisions.

The Corps would be a mechanism by which the "Establishment" could provide individuals with the opportunity to serve a social need pertinent to today's complex problems and demands. And it would demonstrate an interest on the part of government in those problems and demands -- a demonstration sorely needed.

#### E. SUPPORT DISCERNIBLE FOR A NATIONAL HEALTH CORPS.

There has arisen over the past six years a social awareness, or at least interest, on the part of large numbers of young health professionals, 14/ 15/ 16/ 17/ 18/ college students and health educators.

The indications of this are manifold and go beyond "uprisings." There are, for example, eight applicants to VISTA for each position filled. The Student Health Organization--whose members come from all health-related fields and include about 1,500 of the nation's 50,000 medical students--has sponsored a number of projects in community health, both summer and year-round

projects, both "successful" and "not-so-successful" projects, but all ventures being an expression of appropriate interest on the part of health workers in people and their communities, related to fulfilling the total health needs of those who might otherwise have had no advocate.

The Student American Medical Association (SAMA), as another voice of young health professionals, has adopted the promotion of involvement with medical-social problems as a major goal. And, indeed, in its last national conference adopted a resolution to expand the Public Health Service to include functions similar to those outlined in the proposal for a National Health Corps.

In a recent conference on Medicine in the Ghetto attended by medical school deans, hospital administrators and other leaders in the medical field a resolution was passed urging the Government to provide opportunities for two years of service in a National Health Corps. 19/

A similar resolution was passed at the 1969 National Health Council Forum on "Health Care Problems of the Inner City."

The AMA's Health Manpower Committee, having reviewed the statistics on medical manpower, and having met with AMA committees and councils, representatives of national health organizations, government agencies, medical institutions, physician specialty societies, and state and metropolitan associations, has "confirmed the critical need for more physicians, for a better distribution of physician resources, and for more allied health personnel in all categories." 20/

In the government, Assistant-Secretary Egeberg has suggested the possibility of creating a one-year tour of duty for all physicians upon completion of internship. 21/

Dr. Milton L. Bankoff, consultant to the Office for Group Practice Development, Division of Health Care Services, Community Health Service, has issued a memorandum urging the assignment of military medical officers to community health programs (see attached memo.).

Discussions with Mr. Charles Avery of SAMA indicate a willingness to explore interest, through a questionnaire, of SAMA members in the National Health Corps, as described above.

In sum, while there have been no specific proposals or descriptions of a National Health Corps, there have been a number of vague but genuine expressions of interest in some sort of program such as the National Health Corps described above.

F. SUMMARY.

The nation has promised the availability of good-quality medical care to all its citizens.

There is today a critical need for health manpower--"the right numbers and kinds of people in the right places...Health manpower resources are not distributed equitably in the different parts of the Nation," 22/ nor in different parts of the States, nor in different parts of the Cities.

A National Health Corps is suggested as a means of meeting the problem of maldistribution. As described herein, there would be established:

- (1) a National Health Corps made up of enlisting physicians, nurses, dentists, pharmacists, podiatrists, health administrators, lawyers, health technicians and other health personnel (actual or potential).
- (2) a National Health Corps Executive Council, with responsibility for personnel, planning, evaluative, legal and legislative, and coordinative functions and policies of the NHC.
- (3) a plan for revision of personnel policies of the USPHS insofar as is necessary to establish the NHC, including provisions for non-commissioned officers, for reviewing present job functions, and for inclusion within the NHC service obligations of the PHS toward Indians, seamen, prisoners, etc.

Rationale for having service in the NHC satisfy military obligations is put forth.

Further advantages of a National Health Corps, to the corpsman, the community and to the nation are outlined.

Evidence of support for a concept like the NHC is cited.

Finally, it is proposed that pursuant to the three foregoing suggestions, investigations be made toward finding out more precisely probable personnel needs; budget requirements; legal, political and organizational problems; and collection of any necessary data--all directed toward developing and supporting necessary legislation to establish a National Health Corps.

Laurence J. Platt, M. D.  
Office for Group Practice  
Development  
Division of Health Care Services  
Community Health Service

8/20/69

Attachments

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REFERENCES

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- 22/ "Health Manpower, Perspective; 1967" HEW, PHS, Publ. No.  
1667 USGPO, Washington, 1967.

*Memorandum*

TO : Director, Community Health Service      DATE: August 5, 1969  
THRU: Acting Director, DHCS, CHS  
THRU: Acting Chief, Office of Group Practice, DHCS  
FROM : Milton L. Bankoff, M. D., Consultant to the  
Office of Group Practice Development, DHCS, CHS

SUBJECT: Military medical officers to be assigned to community health programs

1. A great deficiency exists at the present time of young physicians who are willing to work in the inner city.
2. Many seniors and interns have expressed a willingness to work with the poor, and a desire to do this rather than to serve in the armed forces.
3. The mechanics for developing a program of two-year service for the poor within the framework of the Commissioned Corps of the Public Health Service is already in being.
4. Such a program, with an enlargement of the commissioned corps to approximately an additional 1,000 physicians, would require only enabling legislation for salaries and decision to go ahead with the concurrence of the armed forces. This of course is easier said than done, but might be feasible if it were pointed out that this would in no way detract from the present draft call up, since the necessary draftees to fill the armed forces billets would still be available from the usual sources.
5. Politically, such an enlargement would help a great deal to improve the image of the current administration with the poor, and especially the black poor.
6. By using personnel of this type to supplement existing groups and programs in community medicine now serving the various communities across the country, a continuity would be established since the men would not be continuously replaced by an entirely new phase, but rather would be coming and going from the program which would continue for an indefinite period. The permanent members of the program would be the faculty members, the neighborhood community physicians, and the community board itself involved in the program.



The concept could be the subject of discussion on a Departmental level before involving the requisite agencies who also must be consulted; namely, the Selective Service Board and the Department of Defense.

From the standpoint of the Group Practice Program, such a commissioning of young physicians who would become involved in an inner city program, utilizing the group practice concept in delivery of the best possible quality health care to poor communities, both rural and urban, could be stimulating to the formation of group practice on a nationwide basis.

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