THE IMPACT OF FEDERAL HEALTH LEGISLATION ON THE DIETETIC PROFESSION

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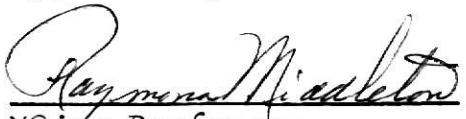

Major Professor

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INTRODUCTION

Passage of the 1965 amendments to the Social Security Act (P.L. 89-97), incorporating health insurance for the aged, brought to fruition many years of conflict to assure health care as a statutory right for this group. Although the act fell short of the program envisaged by its early proponents, it was by far the broadest extension of the social insurance principle in the 30-year history of American social security. For most persons 65 years of age and older, Medicare provides payment for a basic program that includes inpatient diagnostic services, hospitalization, and post-hospital benefits in an extended care facility and at home.

The principle of reasonable cost reimbursement for the providers of services offers many opportunities to assure the quality and continuity of patient care. Each health care institution will have the opportunity to insist on comprehensive dietetic and nutritional counseling; not only for therapeutic purposes, but for balanced diets and proper nutrition for patients of all ages.

The past decade has been marked by increased concern for identification of health needs and development of new approaches in providing health care. During this period, dietitians and nutritionists have been challenged time and again with new opportunities for service and with the need to explore and identify their roles in "newer" health programs (Piper and Youland, 1968). As health affairs move into the area of social and

political planning, the measure of the success or failure of the dietetic profession to survive may well be its ability to adapt to new responsibilities and to develop new ways of providing services.

Discussing an overview of Medicare at The American Dietetic Association meeting in 1967, Dr. John Cashman of the United States Department of Health stated "As individuals and as members of The American Dietetic Association, you must move to meet the new and exciting challenges to your profession" (Cashman et al., 1968). Piper and Youland (1968) added that in this milieu of progressive health legislation and changing pattern for providing health care, the dietetic profession must scrutinize its goals and functions and identify anew its place in medical care. The basic question is how can the profession extend itself to meet present and future needs?

A survey published in the Journal of The American Dietetic Association in 1964 estimated between 3,000 and 3,500 positions for dietitians in hospitals were then unfilled. In 1956, less than 1 per cent of the nursing homes and related long-term care facilities employed dietitians (Cashman et al., 1968). Dietetic personnel needs in hospitals over the next five to ten years have been estimated. In view of the projected growth and replacement needs, and assuming that utilization of dietitians continues as at present, 11,900 more will be needed in hospitals in 1972 and 17,922 by 1977 (Hubbard and Donaldson, 1968). A recent survey by the American Hospital Association and the Public

Health Service indicated that 1,600 hospital dietitians are urgently needed and 3,600 are required for optimal care (Piper and Youland, 1968). Public Health Service estimates that 1,000 dietitians are needed to provide full- or part-time consultation to certified extended-care facilities.

Emphasis on improved health care and increased availability of government funds have tended to heighten existing shortages of all health professionals. Wagner (1967) stated

> All categories must look critically at their profession and develop new ways of providing their specialty service. They must delegate traditional activities to sub-professionals and in turn accept activities from other disciplines.

The objectives of this report are to review and report literature concerning Federal Health Legislation and assess its impact on the dietetic profession.

REVIEW OF LITERATURE

Legislative History of Federal Health Insurance

Legislation providing health insurance for social security beneficiaries was first introduced in Congress in 1952. It first attracted extensive public attention seven years later, when Congressman Forand, for the second time, introduced legislature that provided hospitalization insurance for the elderly through the social security system. By 1961, the Forand bill had evolved into the King-Anderson bill, the official proposal of the Kennedy and Johnson Administration to meet the special problems of the aged (Social Security Bulletin, 1965).

Conflict for Enactment. The Forand and King-Anderson Bills, as well as the various other bills that have proposed alternative methods of paying the medical bill of the elderly, had their predecessors in the proposals for government financed medical care for the entire population. These similar proposals were put forth in the United States from time to time during the first half of the twentieth century.

The agitation for and against adoption of a compulsory system of medical care insurance in the United States began shortly before World War I. The first period, 1910-1920, reached the legislative stage in several states, but no bills were passed. Action for compulsory medical care insurance appeared to be ill-prepared and hasty, and subsided abruptly as soon as unexpected opposition mustered its forces effectively. The second period, 1921-1933, was a quiet one devoted to the study of basic facts and problems that were only superficially comprehended in the first period. The third period, beginning in 1933, has been characterized by action similar to that of the first period, but on a much broader base of support and opposition and in a profoundly different social, political, and economic context (Feingold, 1966).

During the first period, 1910-1920, according to Anderson (1951), the American Association for Labor Legislation (AALL) was the chief group calling attention to problems of medical care insurance and making concrete suggestions for its solutions. The AALL was organized in 1906 by a handful of prominent economists. By 1913, it had over 3,300 members consisting of economists,

lawyers, political scientists, historians, and members of other fields concerned with social problems. It passed out of existence in 1942. It is important to note that the AALL was dedicated to the improvement of various phases of society within the contemporary economic and social structure and ideology. In 1912, the AALL established a Committee on Social Insurance, the first of its kind in the United States, which in the next few years carried the main burden of the medical care insurance study and activity.

In 1914, a sub-committee of the Committee on Social Insurance was appointed to draft a bill in preparation for an active campaign in the states and in Congress. By the end of 1915, a model bill was drafted to be introduced in several state legislatures in January, 1916. At the same time, Anderson (1951) reported that the American Medical Association had appointed a committee to cooperate with the Committee on Social Insurance in putting finishing touches on the medical sections of the bill.

Opposition emerged rapidly after the AALL unknowingly exposed itself completely. It was naively assumed that a reform which they thought would be deemed good by everyone would triumph on its own merits (Feingold, 1966).

As long as medical care insurance was discussed without relation to specific and concrete action, the potential opponents apparently were not aware of its implications. However, when state commissions were established to study the subject and make recommendations, the proponents were surprised at the opposition's vehemence and gathering strength.

By 1918, the movement reached its peak of activity. At this point, the seemingly favorable attitude of organized medicine turned into vigorous opposition. In 1920, the American Medical Association developed a basic policy and expressed it in the form of a resolution at the annual session of the organization. The end of the controversy over compulsory medical care insurance was just as abrupt as the American Medical Association's resolution was final.

During the second period, 1921-1933, the American Medical Association, at several annual meetings, considered resolutions concerned with definitions of state medicine and similar forms of medical care organized and operated by the government (Burrow, 1963).

In 1921, the Sheppard-Towner bill to provide grants-in-aid to states for maternal and child health programs was up for consideration in Congress. The bill aroused bitter controversy at the hearings and many physicians testified in opposition (Anderson, 1951). Nevertheless, the Sheppard-Towner Act was passed in 1922 with active support from citizens' groups.

Problems regarding the economic and social aspects of medical care were discussed on several occasions in 1925 and 1926 at conferences attended by physicians, members of the public health professions, and economists. The conferences were called to formulate plans for a study of the structure of medical services of the country, especially the economic aspects (Anderson, 1951). As a result of the deliberations of these conferences, the Committee on Costs of Medical Care (CCMC) was established.

From 1928 to 1932, the CCMC released 28 reports on the incidence of illness, the cost of medical care, and related aspects of health (Anderson, 1959). The period seemed to be one of watchful waiting. The effect of the final report dealing with a recommendation for action on the basis of the findings was immediate. Majority and minority reports split the CCMC and supporters of its objectives into fractions. The lead in opposition to the majority was taken by the American Medical Association and some of the physician members of the CCMC.

In the third period, which began in 1933, the recommendations of the Committee of Cost of Medical Care and the reactions to them formed the beginning of the compulsory medical care insurance movement. The main issues and factions were brought to the surface as the movement gained momentum and breadth during the following years. The Federal Government spearheaded the re-opening of the issue of government-sponsored medical care insurance through official committees and legislative activity and later state governments. Accomplishments during this period had conditioned the attitudes and actions of other groups. There had been a general agreement that a problem existed and the depression made it more acute; but there had been profound disagreement as to the solution.

The depression and deliberations over the nature and scope of the impending social security program provided the framework for discussions and action on compulsory medical insurance. The precedent-setting Federal Rules and Regulations No. 7 of 1933

defined policies and procedures under which care might be given to those receiving unemployment relief in the states (Feingold, 1966). Representatives of the American Medical Association participated in the formulation of the rules and regulations and gave their sanction. Access to medical care was then recognized by the government as a basic minimum right, together with food, clothing, and shelter.

In 1934, the President appointed a Committee on Economic Security to recommend a program against misfortunes that cannot be wholly eliminated. Additional committees were established as advisory to this committee with a range of representation from fields of interest and organizations. The research duties of the committee were divided into several problem areas, among them, medical care.

The Social Security Act was passed in 1935. Thereafter the Government sponsored a series of activities which either deliberately or coincidently resulted in the introduction of the first compulsory medical care insurance bill in Congress to attract widespread attention. The following series of activities were enumerated by Anderson (1959):

1. The National Health Survey was made in 1935-36 - a large-scale study of the incidence of illness and the underlying social and economic problems.

2. In 1935, the President appointed the Interdepartmental Committee to coordinate health and welfare activities. They were entrusted with the task of making sure that the provisions of the

Social Security Act were being effectively applied, and suggesting improvements. One of the chief interests of the committee was the problem of medical care.

3. Out of the Interdepartmental Committee was created the Technical Committee on Medical Care in 1937, consisting chiefly of experts from the Federal agencies concerned in whole or in part with health.

4. Early in 1938, the Technical Committee recommended, among other things, a need for a general program of medical care and insurance against loss of wages as a result of illness.

5. Thereupon, the Interdepartmental Committee called the National Health Conference in Washington D. C., in July 1938, to discuss the findings and recommendations submitted by the Technical Committee. Invitations were sent to large groups of people from the medical profession, from agencies working in health, and from labor, industry, agriculture, and other groups of citizens. The purpose of the conference was to clarify issues and stimulate constructive criticisms. No specific recommendations were expected from this conference. The Wagner Bill of 1938 (S. 1620) was the legislative result of these activities.

In 1940, Senator Wagner (New York) introduced a hospital construction bill, requested by President Roosevelt. It was favorably reported by the Committee on Education and Labor and passed by the Senate. It died in the House Committee.

Companion bills, providing for a comprehensive postwar social security program, including a national health insurance

plan financed through a payroll tax, were introduced in 1943 by Senator Murray (Montana) and Senator Wagner and Congressman Dingell (Michigan). The bill died in committee, although it was strongly supported by organized labor.

In 1944, the "economic bill of rights," included in President Roosevelt's State of the Union Message, specified the right to "adequate medical care," and the eighth annual report of the Social Security Board called for compulsory health insurance.

In May 1945, Senators Murray and Wagner introduced S. 1050 which was similar to their 1943 bill. Later in the same year, President Truman proposed a broad legislative program for national health insurance, and the two Senators introduced S. 1606, known as the National Health Act of 1945. Title I provided for expansion of public health services, maternal and child health services, and a system of personal health services to be developed on a social insurance basis. Congressman Dingell introduced a companion bill in the House.

Hearings before the Senate Committee on Labor and Education extended from April through June, 1946. The testimony made a printed record of 3,000 pages. A large majority of witnesses reaffirmed the need for a national program of personal health services to be financed on an insurance basis. No action was taken by Congress.

President Truman's three major messages to the 80th Congress: the State of the Union Message, the Budget Message, and the Economic Report, all called attention to the need for health

insurance. The President submitted a broad public health program and recommended that the Congress lay the legislative groundwork for a national system of compulsory health insurance. Again in May, 1947, in a special message on health, he called attention to the health needs of the nation and recommended enactment of a broad national health program. These recommendations were in line with the popular opinion of the time. A number of polls had indicated growing interest in a comprehensive health program and particularly in a system for the prepayment of medical costs. Hearings were conducted on the bill S. 1320 but no action was taken.

In 1949, President Truman called again for a national health insurance plan financed by social security taxes, and the Murray-Wagner-Dingell bills were once more introduced as S. 1679 and H.R. 4312. Hearings by congressional committees evoked sharp controversy. Organized labor, many northern Democratic Congressmen, and private organizations of professional workers in the social welfare field favored broad federal responsibilities in this area. Strongly opposed, in addition to the American Medical Association, were the American Dental Association, the American Pharmaceutical Association, Blue Cross-Blue Shield commissions, the U. S. Chamber of Commerce, the American Legion, the Farm Bureau Federation, National Grange, Health Insurance Council, Health and Accident Underwriters Conference, and others. No action was taken on either bill.

During his campaign for president in 1952, General Eisenhower opposed compulsory national health insurance as "socialized medicine," but promised to help needy persons meet the costs of health care. In 1954, he proposed that the federal government reinsure private insurance companies against unusually heavy losses on health insurance; and H.R. 8356, incorporating the proposal, was introduced in Congress by Representative Wolverton of New Jersey. The theory underlying the bill was that insurance carriers would become more enterprising in their coverage and benefits if protected by reinsurance.

The President's reinsurance proposal was reported by both House and Senate committees. Following a floor debate, the House voted 248 to 134 to recommit the bill, and no further action was taken.

In 1952, the first bills that would have provided hospital care only for Old Age Survivors Insurance beneficiaries aged 65 and over were proposed to the 82nd Congress by Congressmen Dingell and Celler (New York) and Senators Murray and Humphrey (Minnesota). These were H.R. 7484 and 7485 and S. 3001. The program would have functioned through the Social Security System, but certain administrative aspects would have rested with the states, acting as agents of the federal government whether in making payments to the hospitals or in using nonprofit health insurance plans to make such payments. No action was taken on the bills. Identical or similar bills were introduced in 1955, 1956, and 1957.

In 1957, Congressman Forand (Rhode Island) introduced a bill (H.R. 9467) that would have provided OASI beneficiaries with up to 120 days of combined hospital and nursing home care, plus surgical benefits. Administration was to be solely through the federal government, using such nonprofit agencies as might be found desirable. It was the debate on this bill that created a more general interest in the subject of providing health care for the aged. The House Ways and Means Committee held hearings on the bill, but failed to report it out. The 1959 Forand bill, slightly modified, was reintroduced and hearings were held. No action was taken by the committee.

In 1960, Senator McNamara (Michigan) introduced a bill (S. 3503), based on the Senate subcommittee's report on the aged, that was designed to overcome certain criticisms of the Forand bill. It was sponsored by 18 other senators, including Senator Kennedy (Massachusetts). Benefits for persons covered by social security would have been financed by higher payroll taxes and for other aged people by appropriations from the general revenues.

Other bills introduced that year would have increased OASDI cash benefits so that the aged and disabled might arrange for their own medical care; would have provided for credits on federal income taxes for health insurance premiums; would have provided for federal grants-in-aid to assist the states in establishing protection for their aged citizens; or would have increased existing federal grants to the states to aid the medically indigent.

The Committee on Ways and Means held no hearings but gave executive consideration to the Forand bill and to several other proposals having to do with medical care of the aged. On September 13, 1960, the Kerr-Mills bill (P.L. 86-778) was accepted by both houses and approved by President Eisenhower.

President Kennedy's Health Message to Congress in February 1961 recommended the addition of health insurance for the aged to the social security system. Senator Anderson and Congressman King (California) then introduced another version of the program to provide medical benefits to the aged with social security financing H.R. 4222 and S. 909. The House Ways and Means Committee was opposed to the bill, 18 to 7, and did not report it out.

President Kennedy's State of the Union Message in January 1962 again called for health insurance for the aged added to OASDI. His special message on health in February repeated the request for health insurance protection for the aged through the social security system.

Besides the King-Anderson bill, numerous other proposals for hospital insurance were before the Congress. Among those with a social security approach were the McNamara bill (S. 65), the bill introduced by Congressman Lindsey (New York) (H.R. 11253), and one by Senator Javits (New York) (S. 2264).

Continued inaction by the House Ways and Means Committee led to an attempt to obtain hospital benefits for the aged by amending the public assistance amendments, then on the Senate floor.

The amendment was tabled by a roll call vote of 52 to 48. For the second time, the social security approach had been taken to the Senate floor and defeated.

In a special message to Congress called "Aiding our Senior Citizens," President Kennedy in 1963 again urged passage of Medicare, and Representative King and Senator Anderson introduced H.R. 3920 and S. 880. This was essentially the compromise plan offered on the Senate floor in 1962. The bill remained locked in the Ways and Means Committee.

In January 1964, a group of Republican senators who favored the social security approach introduced a new bill that would use both governmental and private insurance, with benefits available to all citizens 65 or over. No action was taken on this bill.

Instead, the House Ways and Means Committee, in June 1964, voted to add a 5 per cent increase in social security benefits, financed by increased payroll taxes, but no health benefits. A higher benefit presumably would have permitted social security beneficiaries to pay their own doctor bills or buy insurance. The average social security benefit was $77.00 per month. Raising it by 5 per cent would have given $3.85 more, hardly enough to pay the premium on the least expensive insurance.

The House of Representatives approved the bill, but when it reached the Senate, amendments were added. The Senate approved the amendments and adopted the bill by 60 to 28. The bill then went into conference and failed to reach agreement before Congress adjourned, with the result that neither health benefits

nor higher social security benefits were provided by the Congress in 1964.

President Johnson's State of the Union Message in 1965 listed as an item of high priority "help for the elderly, by providing hospital care under social security and by raising benefit payments to those struggling to maintain the dignity of their later years." His measage on the nation's health also strongly supported hospital insurance for the aged.

Congressman King introduced H.R. 1 to provide hospital insurance under social security and an increase in cash benefits. Senator Anderson introduced S. 1, the Senate companion Bill. The bills embodied the Administration's hospital insurance proposals and contained many of the provisions extensively considered by the Congress in 1964. The bill did not include a separate payroll tax but was to be financed by a specified proportion of social security contributions to a separate hospital insurance trust fund.

The American public appeared to favor Medicare. The Gallup Poll in December 1964 had asked the following question of a sample of the nation's adults, including both old and young:

> Congress has considered a compulsory medical insurance program covering hospital and nursing home care for the elderly. This medical care would be financed out of increased social security taxes. In general do you approve or disapprove of this program?

Approval was voiced by 63 per cent of the respondents; disapproval by 28 per cent; and no opinion by 9 per cent (Greenfield, 1966).

The House Ways and Means Committee considered H.R. 1 for six weeks, holding extensive hearings, and then approved by a 17 to 8 vote a bill to replace the Administration's proposal with an unprecedented package of health benefits and social security improvements. From then on the bill, introduced by Chairman Mills as H.R. 6675, had smooth sailing despite the continued sniping by the American Medical Association.

On July 27, 1965, the House approved the bill and the Senate voted to approve it the next day. President Johnson signed the bill July 30, in the presence of former president Truman at Independence, Missouri, in recognition of Truman's effort in behalf of health insurance.

Overview of Medicare and Medicaid. The term "Medicare" itself is somewhat ambiguous. It was first applied to a program of federally subsidized medical care for dependents of military personnel (Fiengold, 1966). During the discussion of proposals for hospital insurance for the aged in the last years of the Eisenhower Administration, the Secretary of Health, Education and Welfare, Arthur Flemming, applied the term to these proposals. Since then, the term has been used by headline writers and others to refer to a wide variety of medical-care programs which range from the complete provision of all medical services for the entire population to the provision of selected services for a portion of the population.

For most persons 65 years of age and over, the new law provides a basic program that includes out-patient diagnostic tests,

hospitalization, post-hospital care in an extended care facility, and certain post-hospital health home care. A supplementary, voluntary, medical insurance program covers physicians' fees, including surgery, and various other services not provided in the basic plan.

Total social security taxes were raised by three-fourths of 1 per cent the first year of operation, and the earnings were based on $6600. Trust funds, separate from the old age and survivors' insurance and the disability insurance trust funds, were set up for each plan.

The two programs are based on the principle of co-insurance. The patient must contribute to the cost of diagnostic tests, hospitalization, and nursing home care during any illness. For medical benefits, he must pay a monthly premium, plus a deductible amount and 20 per cent of the remaining costs during any calendar year. Out-of-pocket costs for both programs may be raised in the future to keep the program self-supporting.

Individuals entitled to insurance benefits under the act are guaranteed the right to obtain health services from any institution, agency, or person qualified to participate in the program if the institution, agency, or person has undertaken to provide service. The right to such free choice has been offered in virtually every health insurance bill before the Congress.

The act sets up a Health Insurance Benefits Advisory Council, composed of representatives of the professions and the public, to advise the Secretary of Health, Education, and Welfare on general

policy matters in the administration of the program. A similar provision has been included in all previous health insurance bills.

Many compromises were made to produce the final form of Medicare, most of them to propitiate its opponents. While there is still opposition to the program by a substantial segment of the medical profession, it must be pointed out that without its cooperation, the program cannot function (Greenfield, 1966). The physician is the key figure in determining utilization of health services. No one may enter a hospital without a physician's certification. A physician must order diagnostic tests, prescribe drugs and treatment, and determine the length of stay. For post-hospital extended care, a physician must certify the need for skilled nursing services, as well as the need for any service given in the patient's home.

Physicians and surgeons are under no legal obligation to participate either in the basic hospital or the voluntary medical insurance program. Under the present system for medical insurance, however, the patient may pay his doctor directly and then be reimbursed by the government or fiscal agency handling payments to the extent allowable under the regulations.

When Congress approved Medicare in 1965, it also enacted a separate program known as Medicaid. This provided increased federal funds to stimulate improved state plans for medical care of persons qualifying under the public assistance titles of the Social Security Act and to meet their medical expenses. Although

Medicare received more attention from the public, the welfare experts regarded Medicaid as a greater social gain in that it could facilitate eventual provision of medical care for all needy persons (Greenfield, 1968). Medicaid, moreover, was supportive of Medicare in that the law required state plans to meet the full cost of Medicare fees and deductibles for aged persons eligible for aid. This program was amended in 1967, chiefly to reduce federal costs by lowering the income eligibility ceiling of persons in whose medical care costs the federal government would participate.

Dietetics and Health Care

Projected Manpower Needs. Manpower planning has been defined as the process of insuring that the right numbers and kinds of people are at the right places at the right time doing things for which they are economically most useful. Beeuwkes and Yakel (1962) reported a survey of American Dietetic Association members. The survey showed that of 1874 members not then employed, more than half (1075) expected to return to professional employment in the future.

In a review of the 1950-60 decade, Van Horne pointed out, "As far back as 1942 The American Dietetic Association first became concerned about the profession's inability to meet the needs for dietetic services, especially in small hospitals." These needs have been greatly increased now by the large number of nursing homes and extended care facilities that have come into

existence. Several avenues have been explored since that time to help fill the ever-increasing need for dietitians.

In the spring of 1963, The American Dietetic Association, in cooperation with the American Hospital Association, surveyed food service management personnel in hospitals (A.D.A., 1964). The results of this survey were reported in terms of size of the hospital. In small hospitals under 100 beds (57% of all hospitals in the continental United States fall into this category), budget limitation usually restricted the employment of a full-time professionally qualified dietitian. However, it was demonstrated that by making use of the services of dietary consultants, part-time or shared dietitians, small hospitals could efficiently utilize the professional services of a dietitian and still maintain an operating budget. Administrators in 24.5 per cent of the 1806 small hospitals reported dietitians were in charge of food service. Of the 443 reporting, 147 of these were part-time or shared dietitians. There were 857 vacancies in 632 small hospitals for food service supervisors and 165 had openings for part-time dietitians. There were unfilled positions for full-time dietitians in 234 small hospitals.

The second classification of size of hospitals was those of 101 or more beds. Approximately 42 per cent of all hospitals in the United States falls within this size classification, providing 89 per cent of the total beds. In 67.2 per cent of these larger hospitals, dietitians administered the food service. The remaining hospitals had unfilled positions for dietitians.

In 1964, The American Dietetic Association published a survey that estimated between 3000 and 3500 positions for dietitians in hospitals were then unfilled. In 1965, less than 1 per cent of the nursing homes and related long-term facilities employed dietitians.

In 1968, the American Hospital Association and Public Health Service indicated that 1600 hospital dietitians were urgently needed and 3600 were required for optimal care. Public health estimates that 1000 dietitians were needed to provide full- or part-time consultation to certified extended-care facilities. In addition to established positions for public health nutritionists in state and local health departments, a minimum of 300 nutritionists are needed to provide consultation to certified home health agency staffs.

The past decade has been marked by increased concern about the identification of health needs and the development of new approaches in providing health care. The American public demands high quality health services of all types for all ages and health conditions. They expect to find these services in cities and rural areas now and continuously in the future.

Hospitals and all health care agencies have felt the stress for these demands. Piper (1969) pointed out that if manpower needs are met, the thinking and energies of all who are involved with research, education, and service in the fields related to health are required. New relationships and responsibilities will be essential and will require understanding on the part of public,

private, federal, state, and local organizations, institutions, and agencies involved in health care.

On January 1, 1967, the Bureau of Health Manpower was established, thereby creating for the first time in the federal government a major organizational unit to focus attention on health manpower problems. This Bureau was given primary responsibility for evaluation of available health manpower needs and resources, stimulation of improved health manpower utilization, exploration of new kinds of personnel, and support of innovation and improvements in professional and technical education.

The Division of Allied Health Manpower, one of the five divisions which comprise the Bureau, is directing its energies to those professional, technical, and supportive occupations in the fields of direct health care, community health, and environmental health services. The Division is specifically responsible for the programs authorized under the Allied Health Professions Personnel Training Act of 1966 (P.L. 89-751) as amended during the 90th Congress by the Health Manpower Act of 1968 (P.L. 90-490).

Provisions of the 1966 Act exemplify ways in which the Federal government can help meet the responsibilities for health which all share. The Act recognizes the need for all types of allied health personnel and presents an unprecedented opportunity for the allied health professions.

Dietitians are among the nine allied health professions eligible for support at the baccalaureate and graduate levels of

training under these programs. Dietary technicians are included in the 12 allied health professions eligible for support at the associate degree or equivalent level.

Basic Improvement Grants are designed to increase the number of persons prepared to fill staff positions and to strengthen and improve the educational quality of the curricula. The number of centers training dietitians and dietary technicians, the student enrollment with the amount of support from the Basic Improvement Grants for academic years 1967-68 and 1968-69 are summarized in Table 1. In the 75 colleges and universities receiving grants for the training of dietitians, the enrollment in the junior and senior years has increased from 1607 in 1967-68 to 1945 in 1968-69. Grants to these institutions have been approximately $1.5 million out of a total awards at the baccalaureate level of $10.3 million for all paramedical degrees (Piper, 1969).

Of the ten associate degree programs that have received grants, the enrollment of dietary technicians in the second year of training has increased from 215 in the academic year 1967-68 to 267 in 1968-69. Piper (1969) stated these programs have been supported with more than $200,000 out of total awards at the associate of arts or equivalent level of $217 million.

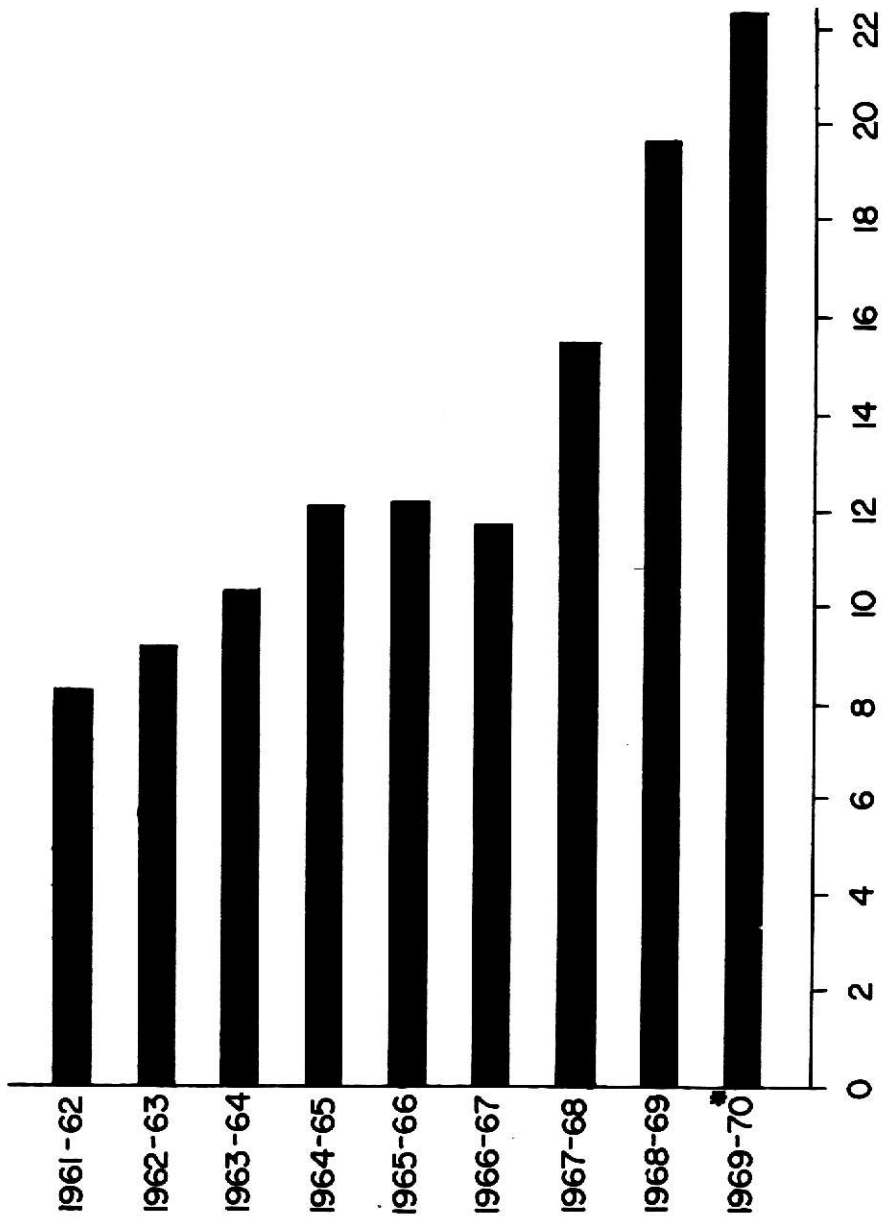
Growth in enrollment of junior and senior dietetics students for the academic years 1961-62 through 1969-70 is shown in Fig. 1. It is of interest that enrollment of dietetics students doubled from 1961 to 1967, and if the projected enrollment becomes a reality, it will be about two and one-half times that of 1961-62.

Table 1. Summary of support in dietetics through Allied Health Basic Improvement Grants, academic years 1967-68 and 1968-69.

Academic year	Number of training centers	Student enrollment	Amount of support
		Dietitians	
1967-68	75	1,607	$ 356,014
1968-69	75	1,945	1,127,442
		Dietary technicians	
1967-68	10	215	57,914
1968-69	10	267	144,936

In discussing educational grants for manpower needs, Piper (1969) pointed out the need for teachers, supervisors, specialists, and administrators. The legislation, therefore, specified that a recipient, to be eligible for an advanced traineeship should plan to use this training as a teacher, supervisor, administrator, or specialist. The actual utilization of the advanced training will be a part of the overall evaluation of the legislation in relation to its effectiveness in helping to provide health manpower.

The Allied Health Manpower Act also provides grants for the development of curricula and educational methods for the training of health technologists and technicians. The original 1966 law authorized grants to qualified allied health training centers for projects to develop, demonstrate, or evaluate curricula for the training of new types of health technologists. The Health



* Projected enrollment for academic years 1968-69 and 1969-70

Fig. 1. Student enrollment in Dietetics, academic years 1961-62 through 1969-70.

Manpower Act of 1968 modified the language of the section on Developmental Grants to broaden the purpose to include support for the development of educational methods for known as well as new types of health technologists. In addition, the amendment extended eligibility to public or non-profit agencies, institutions, and organizations, thus making it possible for competent resources other than junior colleges, colleges, and universities that qualify for the Basic Improvement Grants, to submit proposals for grants. This broadened authority for Developmental Grants enables the consideration of a wider range of projects and is a potential resource for innovative instructional programs for dietitians and dietary technicians.

The terminology used to identify various levels of training and education under the allied health occupations are: people trained in short-term, on-the-job programs are identified as "aides"; those trained in formal educational programs, including theoretical and practicum courses, usually leading to a certificate or the associate degree, are called "technicians" or "assistants"; and those who have received at least a baccalaureate degree, usually including some practicum experience, are considered "technologists."

Applying this terminology, in the field of dietetics, the title "dietitian" is used for the professional person and indicates at least baccalaureate level preparation. The title increasingly associated with the second level of preparation, such as an associate degree, usually from a community college or

junior college, is "dietary technician." The name for the third level worker, "food service supervisor," implies on-the-job or specialized training of less than two years' duration after high school. Thus the three levels of occupations for the dietetic field are: dietitian, dietary technician, and food service supervisor.

Considering health legislation, expanding opportunities in health programs, and personnel shortages, three major roles are suggested by Piper and Youland (1968) for dietitians and nutritionists in the future: (1) executive and leadership roles, (2) medical care team roles, and (3) consultant roles.

Changes in the Scope of Duties and Responsibilities. To better understand the various roles and duties of dietary personnel, the following definitions are used: (The American Dietetic Association, 1964)

(1) dietitian - A member of The American Dietetic Association or one who is currently qualifying for membership. A professionally educated person who has a baccalaureate degree and advanced education and is proficient in the application of the principles of those sciences to feeding individuals in groups.

(2) shared dietitian - A member of The American Dietetic Association or one who is currently qualifying for membership. A dietitian who assumes the responsibilities of the chief dietitian for more than one hospital.

(3) part-time dietitian - A member of The American Dietetic Association or one who is currently qualifying. A dietitian who is responsible for the administration of the foods department but who works on a part-time basis.

(4) consultant dietitian - A member of The American Dietetic Association or one who is currently qualifying for membership. The consultant's duties are to observe, advise, and guide a dietary food service. She does not have direct control of the department.

(5) dietary technician - a definition of responsibilities has not been published by The American Dietetic Association but this person would have an associate degree from a two year course and would perform intermediary duties between the dietitian and food service supervisor.

(6) food service manager - A person who may or may not hold a baccalaureate degree, who has had experience in food service administration, becoming proficient in food service management and who is designated as the head of the institution food service department.

(7) food service supervisor - An individual who by special education, training, and experience is capable of performing supervisory duties delegated by the person in charge of the department. In small organizations this position is sometimes called cook-manager.

(8) cook manager - A person who by training education or experience assumes responsibility for food and beverage preparation in hospital, nursing homes, or extended-care facilities food service department and is designated as the person in charge.

An American Dietetic Association report in 1965 updated the traditional responsibilities of dietitians. It was divided into duties of a chief dietitian and the four areas of responsibilities; namely, administrative, therapeutic, education, and research. These responsibilities have been and are still mostly supervisory in nature and necessitate much time spent in the confines of the dietary department. By effective use of sub-professionals, the dietitian will be freed of many routine supervisory duties, thereby giving her time to be of invaluable benefit to the overall health care of the patients and to contribute to health education in the community in which she lives and works.

Role of the Dietary Consultant. With the advent of Medicare, many hospitals and nursing homes were in need of professional

dietary consultation. This pressing need brought many non-working professionally qualified dietitians back into the work force to help relieve the manpower shortage. As dietitians assumed the role of a consultant, many questions were raised both by administrators and dietitians as to the scope of responsibilities.

The role of the consultant dietitian has been discussed by a number of American Dietetic Association members in various professional journals. Montag (1966) presented an overview of the Role of the Dietary Consultant at the Institute for dietary consultants to nursing homes and small hospitals, Ames, Iowa. She stated, "To serve most effectively, the dietary consultant must have a clear understanding of the concepts of line and staff functions as defined by the proponents of industrial management." The term "line," as defined, meant those positions and elements of the organization that have authority and responsibility for accomplishment of primary objectives. The term "staff" related to those positions that have responsibility and authority for providing advice and service in the attainment of objectives.

The definition of "dietary consultant" published in the Dictionary of Occupational Titles reads:

> Dietary Consultant - (profess. & kin.) 077.128. consultant dietitian; institutional, nutrition consultant advises and assists public and private establishments, such as child care centers, hospitals, nursing homes, and schools, on food service management and nutritional problems of group feeding; plans, organizes and conducts such activities as in-service training, conferences, and institutes for food service managers, food handlers, and other workers. Develops and evaluates informational materials. Studies food service practices and facilities,

> and makes recommendations for improvement. Confers with architects and equipment personnel in planning for building or remodeling food service units.

Since both "staff" and "dietary consultant" are defined in terms of advice and service, the role of the consultant can be described as a staff function. The verb "directs" is conspicuously absent from both definitions. It is the verb "directs" that differentiates line from staff or the full-time and part-time dietitian from the dietary consultant.

Full- and part-time dietitians have the power to direct, for they carry full responsibility. The dietary consultant lacks the power or administrative responsibility for making decisions and taking action. For this reason, there must be a food service supervisor on the scene who is charged with the task of food preparation and service and through whom the consultant can work. Spears (1965) stated that she would not begin work in any hospital until there was a person responsible for the dietary department through whom she could work. This meant that the administrator had to promote the best employee. Spear recognized that her services would not be effective if there was no one to carry out her recommendations.

The consultant's role is limited to that of advising and counseling the food service supervisor. A consultant is constantly trying to improve standards within an organization. She does not establish standards, nor does she maintain them. A consultant is a professional person, selling herself and her knowledge and ideas to the administrator, doctors, and institution's staff.

Montag (1967) listed conditions that would help promote effective consultation. First, the administrator should clearly explain the function of the consultant to the supervisor, as well as the two-way relationship that should exist between them. The consultant must realize that the position of consultant requires unusual personality. Her approach and attitude will set the tone for the relationship. Since motivation is largely a matter of leadership, it is the responsibility of the consultant to motivate the supervisor so that she will be eager to adopt her recommendations. Food service supervisors must be informed that recommendations are based on established standards and are not given as criticisms. The food service supervisor must assume responsibility for implementing new programs. Finally, the dietitian should bring such intangibles to the job as patience, reliability, tolerance, flexibility, and professional ethics.

In whatever role she is engaged to work at a particular time, she is there to handle the problem in a constructive way. She must have the facts, be willing to ask advice, and have the patience to find out what is wrong.

There are several basic approaches to dietary consultation. The following information will help clarify these approaches. The self-employed dietary consultant works on her own. According to McRae (1967), certain factors are necessary to establish a private practice. A person must have sound financial backing and be able to live several months without income from the practice. Funds are required to equip and operate her facility for at least

six months. The consultant, in a private venture, can choose to work in hospitals, nursing homes, or extended-care facilities or can establish a practice of private patients from doctors' referrals in the surrounding community. The latter service of private patients takes much longer to establish.

Williams (1967) discussed the services of self-employed dietitians in nursing homes. When a consultant agrees to work with a nursing home, she must arrive at an agreement with the administrator as to her direct responsibilities, the needs of the food service department, the goals for food service, and specific contributions the dietitian can make to accomplish them. Agreement must be reached as to how much time in a regular period a consultant must spend to accomplish what is expected of her. Another point was the amount the consultant would be paid for her services, either as a fee or at an hourly rate. Her fee must be higher than that of her full-time salaried counterpart, because the part-time consultant receives no benefits such as social security, insurance, paid vacations, holiday time, and sick leave. She must also consider her travel expense, travel time, and any work done at home or in her office. All these points should be understood and the agreements made in writing.

A group practice or legal partnership may include two or more dietitians who join forces to supply needed services to hospitals, nursing homes, or extended-care facilities. In the partnership of Eyer-Knoll (1968), the two dietitians divided the duties into therapeutic and administrative and worked together as

a team. Purchasing guides were prepared, recipes, job descriptions, and so on. A workshop was planned for the cook-managers in the institutions where they were working. Clients were visited together on a regular basis. The aspect of having someone with whom to discuss problems has been valuable, they reported.

Steps for organizing a legal partnership should be approached in a professional, dignified manner, applying business principles. The following actions could be taken to establish the business. If room is not available in the home, office space in a convenient location could be leased. Next, obtain services of a telephone exchange; have an attorney draw up partnership agreement; then, purchase books, materials, periodicals, and attend work-shops and refresher courses. The last step is to become acquainted with medicare requirements; that is, the Conditions of Participation for Hospitals, Nursing Homes and Extended Care Facilities (Eyer-Knoll, 1968).

Another example of the same legal partnership approach was reported by Woodward (1967). A group of full-time employed dietitians formed a company to formulate guidelines and a program of service for hospitals and nursing homes. They employed other dietitians to act as consultants. Their primary goals were: to improve the effectiveness of the dietary consultant by giving aid, materials, and guidance to each consultant; to provide the dietary consultant with a well paying position and recognition as a member of a professional team; and to provide meaningful service

to an institution in a short time at a reasonable cost. The key word for the consultant policy of this type is flexibility, that is, the ability to adapt the various backgrounds and knowledge of the dietary consultants to the individual needs of each institution.

The package plan is another approach to consultation. Marshall (1967) made these comments, "Each dietitian must work according to her personality and cover all areas of responsibility as previously mentioned. Some dietitians like structure, some fluidity. The package plan is for those who like structure."

The total "package" used by the Food Art Horizon, for whom Marshall was a consulting dietitian, consisted of six parts: (1) six-week menu cycle for general and modified diets, (2) purchasing guide for each week based on these menus, (3) 325 standardized quantity recipes, (4) diet manual, (5) meat specifications, and (6) training manual. In addition, various supervisory forms were used.

This type of program must be presented to the administrator and sold to him as a package plan. Each program must be adapted to meet the special needs of the facility where it is used. The plan was not meant to put all nursing homes or hospitals into the same mold, but was intended as a working tool to help the dietitian to supervise, to help employees to understand what is expected of them, and to speed training. Weekly visits from a consultant dietitian are essential for a smooth operation.

Advantages of the package plan would appear to be time-saving in developing basic tools of management and the amount of control achieved in dietary department activities. By using the same tools in various homes, the consultant knows how much labor it takes to produce food items on the menu with average employees in institutions of various sizes.

Marshall (1967) pointed out that the program does have some disadvantages, some of which are unique to the package plan, although some are found with any system of consultation. Purchase of the program may be expensive for a small institution, but if used properly, it usually pays for itself. It is often difficult to convince the dietary department and nursing staff to change old habits and accept a new program.

The fourth approach is the dietary consultant who works for a group of homes under one management. Basic duties and responsibilities are the same as for the consultant, as discussed in the preceding plans. However, there seems to be some distinct advantages according to Oliver (1967). Perhaps the greatest of these is the flexibility of time. Normally, time spent in each facility is based on the number of patients and usually must be allotted accordingly. However, when all homes are under the same ownership, it is possible for the dietitian to adjust the time spent in each facility according to current need.

Other advantages may include the following: group purchasing from a central office, leading to better budgetary control; control of administration of dietary personnel, such as hiring,

counseling, evaluating, terminating, and in-service training; increased contacts with patients and physicians.

DISCUSSION

Increased urbanization of the entire population, including the aged, may well account for the greatly increased need for medical care through a broad-based insurance program. In earlier days, when employment was largely agricultural, it was not difficult for elderly persons to continue farm work, even though the effort put forth was less than in their youth. And farm homesteads, unlike city apartments or small suburban homes, permitted aging people to live with their children or families.

Today's industrial society offers little opportunity for the employment of older workers. In industry, the retirement age frequently begins at 45. Older people, moreover, no longer wish to rely on their children for support and sometimes the children cannot financially accept responsibility for this support. The problem is intensified by medical advances which have made possible a longer span of life, increasing both the number and proportion of older persons in our population. In 1900, only one out of 25 persons was 65 years of age or older; today one out of 11 is in this age group.

Greenfield (1968) provided statistics concerning the aged population of our nation. In 1965, there were 18 million persons aged 65 or over in the United States, more than 9 per cent of the population. This proportion was expected to increase only

slightly in the ensuing decade. Nevertheless, the estimates for 1970 showed 20 million persons aged 65 and over. Their average age will be higher than in 1965, since the greatest growth was forecast in the oldest age bracket, 75 and over.

Half of all aged persons were married and living with a spouse. But nearly 40 per cent were widowed, and the majority of these were women, almost half of them 75 and over. One out of four elderly persons lived alone or in a lodging house. One out of 25 was in an institution.

Health problems are a major concern of the aged population since advancing age is accompanied by a decline in health and physical capacity. Aged people utilize health facilities and medical services more than younger persons. They use a greater volume of physicians' services and are admitted to hospitals more often and stay longer. They are primary users of nursing homes and other long-term care facilities and receive a greater amount of home care. They need and use more drugs.

The likelihood of older persons being chronically ill is twice as great as for persons under 65, and they are more often partially or completely limited in activity. Data from the National Health Survey of 1960 showed that about four out of five had one or more chronic conditions, as contrasted with two out of five younger persons. The incidence of chronic illness and the extent of disability due to chronic illness increase with age.

Persons 65 years of age and over require two and one-half times as much hospitalization care as do people under 65.

Thus the annual hospitalization rate per 1000 people was 2800 days for the aged but 900 days for younger people.

Although voluntary sickness insurance for the aged had been growing over the years, the pace was too slow to meet the needs of the rising number of elderly persons. Before enactment of Medicare, only two choices were available to them: a low-cost policy with little coverage, or a high-cost policy sufficiently comprehensive to cover most of their risks. In view of their average low incomes, most elderly persons who had insurance were covered only by low-cost policies with limited benefits.

Medicare provides a fiscal mechanism for paying for health care but it does not guarantee the availability of service. In view of the continuing shortage and maldistribution of health manpower and facilities and the steeply rising prices, there is little doubt that changes in the organization of health services will be required if the needs of the entire population are to be met at a reasonable cost.

Among the recommendations frequently made to rationalize the cost of medical care, are training and use of physicians' assistants and other innovations in medical education, the efficient use of health resources, and the encouragement of group practice of medicine.

Even with federal programs already under way that provide funds for medical and nursing education, and related health professions, the shortage of personnel cannot be overcome in the near future. One solution to the problem may be to increase the

number of professional and subprofessional health workers whose training is shorter and less expensive than the graduate at the baccalaureate level.

The scope of responsibilities for dietitians is being reviewed and revised. In order to meet manpower demands on the dietetic profession, the role of the consultant has become increasingly important.

The dietary consultant's role is to help an administrator of a small hospital, nursing home, or related health care facility arrive at solutions to the problems of providing good food and service, and dietary management for the institution's residents. The line of consultation is first to the administrator. As some of the relationships become established, there may be more delegation of authority to the food service supervisor or the cook-manager. The line of consultation then may be directly to this worker or to both the administrator and the worker.

The first step is essentially a request for assistance. This does not imply, however, that the consultant has no responsibility to inform the administrator of impending need.

Development of mutual respect is the second step. The consultant takes the initiative with recognition of the emotional element involved in the delicate human relationship balance. This entails awareness of her own needs for personal satisfactions and how to cope with situations that may not be to her liking. She must work toward understanding the consultee. Evidence of hostilities or other disturbing reactions may be related

to the basic insecurity of the worker who needs help. The consultant may need to form some judgments on how the worker feels about dietitians in general, or about her in particular.

The third step is joint exploration of the problem. At this point the dietitian is a listener, questioner, and giver of help as the occasion arises. This takes skill, concentration, and the ability to listen so that the problem can be seen from the consultee's viewpoint.

The fourth step is working through the problem to a solution. Recognize that there is always a resistance to change; allow for several possible solutions; recognize the limitations and strengths of the workers within the institution; and above all, acknowledge that the consultant's role is to help the worker clarify the problem and arrive at the best solution.

The steps in consultation are not clearly defined. They overlap and intertwine. Consultation is a dynamic process that requires sensitivity, alertness, and skill. The key difference is in the line of authority. The consultant's success lies in learning the distinction between giving directions and making recommendations.

For many years, leaders in the profession have urged dietitians to delegate responsibilities to personnel with varying degrees of training and experience. Some progress has been made, but all possible avenues need be continually explored. The American Dietetic Association has identified the role of the food service supervisor, cook-manager, and dietary clerical worker

and is working on the role of the dietary technician. With the advent of the Allied Health Professions Training Act, the development of qualified manpower at the second level is being promoted. The addition of the dietary technician further emphasizes the need for the development of progressive steps in dietetics. The careers concept means the formulation of specific titles for professional and subprofessional positions and equating them with levels of responsibilities and minimal education requirements. It behooves the professional dietitian to decide which tasks to retain, which to delegate, and to assist in establishing programs for the subprofessionals.

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THE IMPACT OF FEDERAL HEALTH LEGISLATION ON THE DIETETIC PROFESSION

by

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Various interrelated factors account for the development of a nationwide social insurance program to help elderly people pay their medical bills. Some of these factors are: increased longevity and limited personal resources of the aged; declining health and high medical costs; inadequacy of voluntary insurance; and finally, failure of public assistance provisions to reach the medically needy, those with sufficient income to take care of everyday living, but not enough to pay for medical care.

For most persons 65 years of age and older, Medicare provides payment for a basic program that includes inpatient diagnostic service, hospitalization, and post-hospital benefits in extended-care facilities and at home. Medicaid provides increased federal funds to stimulate state plans for medical care of persons qualifying under Medicare to meet their medical expenses. Medicaid is supportive of Medicare, in that the law requires state plans to meet the full cost of Medicare fees and deductibles for aged persons eligible for aid.

During the past decade, there has been increased concern about identification of health needs and development of new approaches in providing health care. Professional and subprofessional roles are being defined and educational opportunities offered to help fill the manpower needs in dietetics.

With the advent of Medicare, an accelerated pace in recruitment of dietitians was imperative in order to qualify for federal funds. This offered an opportunity for dietitians who had not been actively engaged in dietetics for a few years to again enter

the field. The role of the consultant dietitian has helped to fill this increased manpower need. One dietitian can serve several institutions. A consultant advises, but does not enforce the suggestions; guides employees through in-service training; sets an atmosphere of mutual respect with food service supervisor, nursing staff, and physicians; and works problems through to a solution. Consultation is a dynamic process that requires sensitivity, alertness, and skill.

The manpower needs can be met only by those dietitians and educators who know what needs to be done, how to do it, set goals to meet the needs, and work with other allied health personnel and all available resources. Their efforts will help insure the people of our nation quality nutritional care service.