

The Organization of Personal Health Services

LESTER BRESLOW

Recognition of Need to Organize Personal Health Services

IN 1965, WHILE APPROVING MEDICARE, CONGRESS reflected the prevailing view that such a program should not be used to alter arrangements for medical care. The whole intent was to assure payment for services; even to tinker with the system of health care delivery was looked upon as undesirable. The Medicare legislation specified: “Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any . . . control over . . . the manner in which medical services are provided . . .”¹ Now, just six years later, it seems difficult to understand how Congress could have been persuaded that essentially only more money was needed to improve health care for the elderly, or for that matter any segment of the population, and that no attention to organization was needed.

In 1971, several major health care proposals on the national scene reflect a directly opposite view; for example, the proposals by President Nixon, Senator Kennedy and the American Hospital Association.

President Nixon in his 1971 health message to Congress, after discussing the inflationary rise in health care costs, continued:²

The shortcomings of our health care system are manifested in other ways as well. For some Americans—especially those who live in

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remote, rural areas or in the inner city—care is simply not available. The quality of medicine varies widely with geography and income. Primary-care physicians and outpatient facilities are in short supply in many areas, and most of our people have trouble obtaining medical attention on short notice . . .

. . . Costs have skyrocketed but values have not kept pace. We are investing more of our nation's resources in the health of our people, but we are not getting a full return on our investment . . .

We cannot be accused of having underfinanced our medical system—not by a long shot. We have, however, spent this money poorly—reinforcing inequities and rewarding inefficiencies and placing the burden of greater new demands on the same old system which could not meet the old ones.

The toughest question we face then is not how much we should spend but how we should spend it. It must be our goal not merely to finance a more expensive medical system but to organize a more efficient one . . .

As the first point in his National Health Strategy, therefore, President Nixon called for “Reorganizing the Delivery of Service.”

S.3, introduced by Senator Kennedy and several other Senators, specifies:³

. . . The purpose of this act is—

1. to create a national system of health security benefits which, through national health insurance, will make comprehensive health services available to all residents of the United States, and
2. through the operation of the system, to effect modifications in the organization and methods of delivery of health services which will increase the availability and continuity of care, will enhance its quality, will emphasize the maintenance of health as well as the treatment of illness and, by improving the efficiency and the utilization of services and by strengthening professional and financial controls, will restrain the mounting cost of care while providing fair and reasonable compensation to those who furnish it.

Under the heading of General Policies and Priorities,

. . . the Board shall give priority to improving and expanding the available resources for, and assuring the accessibility of, services to

ambulatory patients which are furnished as part of coordinated systems of comprehensive care . . .

Further, in consideration of standards,

. . . the Board . . . may require the revision of a provider's staffing patterns, or its standards for the selection or retention of professional or other personnel . . .

This legislative purpose, together with the provisions of S.3 for health resources development, for reimbursement incentives and other means to promote change in health care delivery, would implement the notion expressed by Walter Reuther, when he called for a health security program:⁴

We can't solve this problem, in our judgment, by simply relying on ever greater expenditures, tax offsets and other purely financial remedies. What we need is basic surgery to substitute for the present nonsystem a new system that begins to bring about more effective and technologically advanced forms of organization of our national health resources and health services . . . We need to recognize that we have a kind of Model T health care system and that a Model T is not adequate to meet the health care needs of the space age. I think it is important that we understand that the system does not need simply a tune-up or a new set of spark plugs. We ought to take the old Model T system out and put it in a museum where museum pieces reside peacefully with the past.

The American Hospital Association in endorsing the report of its special committee on the provision of health services, *Ameriplan*, agreed that,⁵

. . . the existing system for the delivery of health services must be substantially restructured, including both the methods of delivering health services and the methods of financing health services, so that all available resources may be utilized to provide better health care to all at a reasonable cost . . .

. . . *Ameriplan* incorporates methods of financing as one component of restructuring the system for the delivery of health care. Thus it differs significantly from many current proposals that deal only with the financing of health services and fail to provide a solution to the problem of establishing necessary standards in an organized system for the delivery of health services throughout the nation.

Thus, in the current debate over methods of financing health care, the idea is being increasingly accepted that merely providing more funds is hardly worthwhile. It may even be detrimental in the sense of adding to the inflationary trend without assuring any more or better health care.

Origins of Need for Organization of Personal Health Services

This apparently sudden turnabout of opinion represents public acceptance of what had been understood for several years by serious students of the health care field. For example, Victor Fuchs, in commenting on some of the resistance to change in health care arrangements noted, "The medical profession, or at least a significant portion of it, seems to believe that there can be rapid and far-reaching technical change without disturbing traditional organization of medical practice. This belief is irrational. One clear lesson from economic history is that technical innovation means organization change."⁶

Advances in medical science have resulted in vast technical innovation, which in turn has led to growth in both the size and complexity of health care.

The growing size of the health care industry is often expressed in terms of the dollars (now about \$70 billion annually) or the proportion of the Gross National Product (now about seven per cent) expended for its services. The current employment of more than three million persons in health care also indicates the size of the industry.

Its growing complexity may be illustrated by the changing ratio of types of health care personnel. In 1900, when the image of health care was the physician with his black bag, the ratio of physicians and dentists to other health care personnel was about 1:1. In 1970, when the image of health care was a room arranged for cardiac surgery or for a coronary care unit, the ratio was about one physician or dentist to ten other health care personnel. Differentiation of health care personnel has proceeded rapidly in nursing, among diagnostic and therapeutic technicians and in the medical profession itself. Medical science discoveries, although translated too slowly into effective health services, have stimulated the use of complex and expensive equipment; for example, in the modern radiation treatment of certain forms of cancer, and in renal dialysis.

Each such technologic achievement in itself requires attention to organization. The unfortunate fact, however, is that scant attention has been given to organization of the health care delivery system as a whole, or even to its major segments. A graduate student in public health, Gerald Hanson, has just completed a dissertation using data concerning the radiation therapy situation in California in which he notes:⁷

Comparison of the existing situation with the *Guidelines for Cancer Care* [prepared by the Commission on Cancer (Warren H. Cole, M.D. Chairman)—American College of Surgeons, 1971] shows that with respect to organization, personnel, and some facilities (ortho-voltage and superficial capability) the area as a whole falls far short of the guidelines. With respect to megavoltage radiation therapy units, the area has more equipment available than can be utilized effectively—both from the viewpoint of quality medical care and economics . . .

When current plans have been put into effect, 102 megavoltage units will be installed. This will be enough megavoltage equipment to serve twice the 1970 population of the area . . . this population—doubling is expected around the year 2000 . . .

With few exceptions rational planning based on social need has been conspicuously absent on the American health care scene. Even the Hill-Burton program is now being challenged as insensitive to the need for overcoming economic and racial bias in health care. Class action suits filed in New Orleans and elsewhere allege that hospitals that received federal funds to aid construction do not comply with legal commitments to provide a reasonable volume of services to the poor and without racial discrimination.⁸

The failure to plan effectively for health care and organize it has resulted in major deficiencies as to *cost*, *quality* and *consumer satisfaction*.

Expenditures for physician services themselves constitute less than one-fourth of the total health care *cost* in the United States. Almost all other costs, however, flow from decisions made by physicians that patients have hospitalization, laboratory and other diagnostic services, drugs and other therapy. The failure to organize health care services, along with the fee-for-service system and the current typical “health insurance” plan, encourages physicians to make decisions with bizarre and often costly consequences. Perhaps best known among such decisions is hospitalization for many diagnostic services that could be performed at least as quickly and as well, and far less expensively, outside a hospital. Somewhat more subtle is the case of the internist or other physician

providing laboratory and x-ray services for routine screening in his individual office. Physician ownership or involvement in ownership of hospitals, nursing homes and drug stores has become such a scandal as to stimulate resolutions on the subject by medical societies. Gross excess of services (injections, x-rays, surgery) by some providers also illustrates how unorganized health care coupled with fee-for-service remuneration yields a poor and costly result. As Ray Brown, the health care expert, has expressed it, "Medical care like most things follows the buck."

One might add that this anarchic situation has led to equally bizarre efforts to control costs, for example, by limiting the fees for particular services when the underlying problem is whether the services themselves are appropriate and efficiently organized.

Quality likewise suffers because the failure to organize health care encourages services by persons who are licensed to provide a broad range of services, but are really incompetent to provide many of the particular services that they undertake. For example, a study of the experience of teamsters and their families in New York City disclosed that in 71 per cent of admissions to proprietary hospitals where the patient was under the care of physicians who were not qualified in a specialty and did not have appointments in voluntary or municipal hospitals, the care was judged to be less than optimal.⁹ On the contrary, less than 15 per cent of the admissions to voluntary hospitals affiliated with medical schools where the patient was under the care of physicians who were specialty-qualified or had an appointment at voluntary or municipal hospitals were judged less than optimal. It is sometimes asserted that the quality of health care is a strictly professional matter and the consumer should not concern himself with it. In fact the consumer appears now to have considerable influence on the quality of health care, for example, in demanding injections or other particular procedures of dubious or no value for the conditions presented. Too many physicians accede to or even encourage such consumer expectations, with adverse effects on the quality of care. The fact that health care is so little organized accentuates the difficulties of this kind of situation, both for providers and consumers.

Consumer dissatisfaction with health care appears to be growing precipitously, as indicated by the publication and popularity of several critical books and reports on health care from the consumer standpoint in recent years. A Citizens Board of Inquiry into Health Services for Americans, for example, has recently reported:¹⁰

Americans are angry and frustrated about health services . . .

Most Americans do not have adequate health care; they have crisis care . . .

Having decided where to go for care, the patient must still overcome a variety of obstacles before he receives services . . .

The persistent patient who overcomes the barriers to care may find himself treated with indignity and insensitivity . . .

Sometimes the line between insensitivity and poor quality is blurred . . .

“I’ve seen practically every doctor around here to get fixed up. None of them even examined me, but they charge me \$5. They just ask me what’s wrong, and I tell them, then one doctor always give me a shot, that’s \$3 more, and a prescription, and the other two, why they just gave me a prescription. All this time I was paying all this money for pills and doctors and feeling worse and worse. I swear some of those pills make me sicker . . .”

The patient often discovers that the medical services he has received are more expensive than he expected, and that the insurance for which he has paid so dearly affords him only minimal coverage . . .

Many of the same barriers that deterred the patient from seeking care in the first place interfere with his following through on the medical advice and recommendations he receives . . .

With all the anger and the difficulties, people will still do what they feel they must to get needed health care. While there is great frustration, sometimes even desperation, there is little apathy . . .

The Board concluded that:

Consumers have no real or effective role in the planning, organization or delivery of health care. Providers and other health care professionals are firmly in control of our health care delivery system. Consumers and providers, because they are pursuing different and usually competing interests, are often at odds in determining what health services are needed and how they should be delivered . . .

The Board recommended that:

Health care delivery systems should be organized and made accountable to the public . . . Consumers must be able to establish goals,

objectives and priorities of the newly structured delivery system and make them effective in the organization and delivery of health services . . .

Bases for Organization of Personal Health Services

Underlying any specific model for health care must be some conception of that care as a system, and its purpose.

Most discussions of health care proceed on the assumption that health care is good for people. That assumption needs correction: *some* health care is good for people; a substantial amount of it is harmful (for example, excessive drug therapy); and even more is superfluous. Still, health care is more and more effective in the sense that medical science yields ever greater capability for the prevention of premature deaths and unnecessary disability. The obviously growing effectiveness of health care gives reason for people to seek it.

Health care has been and still is essentially a complaint-response system. The patient brings his complaint to a physician who responds by making a diagnosis and prescribing or carrying out therapy. The purpose is to resolve the patient's complaint. This is the basic pattern not only of practice but also for educating physicians and other health care personnel. The complaint-response system works quite well for the patient who has a severe pain in the abdomen, prolonged cough or other serious symptoms. It is, however, increasingly recognized as insufficient for complete health care whose intent is to avoid premature deaths and unnecessary disability.

Within and alongside the general pattern outlined above another system of health care has been emerging, and is called health supervision or health maintenance. This system has been most developed in the care of children and pregnant women. Pediatricians and obstetricians (and many dentists, too) for years have been maintaining health surveillance over people whose care is entrusted to them. They focus on the norms of health and deviations from the norms, correcting disorders as soon as they are detected and avoiding frank disease. This practice may be termed a health-maintenance system. In a sense it embraces and enhances the complaint-response system because the individuals served are taught to recognize important deviations from the normal and bring these symptoms to

a doctor's attention promptly. Complaints need an appropriate response, but the presentation and handling of them can be more effective as part of a larger health-maintenance system of care.

Many physicians still resist the idea of health maintenance as the basis for a health care system on such grounds as, (1) it would make people too health conscious; (2) it would take too much physician time in chasing "false leads;" (3) symptoms are the most, or the only reliable indicators for physician action, and so forth. Although each of these arguments could be responded to, perhaps here it will suffice to mention that the practice of health maintenance has been spreading beyond women and children. It is now being offered to or even required of army officers, college students, business executives, physicians and others.

Perhaps more important, the technical basis for a health-maintenance system has been developing rapidly during the past two or three decades. It is now possible to maintain surveillance over several important health parameters and to initiate corrective action early, often before symptoms occur. Doubts are often expressed about the value of this approach—for example, doubts about the routine use of the cytologic test for cancer of the cervix (Papanicolaou smear) or intensive treatment of slightly high blood pressure—but evidence continues to mount that such specific efforts are effective and that the concept is valid. Thus studies in California show that five to ten years after the widespread introduction of cervical cytology, mortality from cancer of the cervix suddenly declined far more sharply than previously—just as might be expected from current understanding of the disease and its development. Likewise, studies among patients in the Veterans Administration hospitals have recently demonstrated lower mortality among patients with mild hypertension treated intensively, compared with a control group not so treated.

Parameters for surveillance as a basis for health maintenance, and examples of deviations include:

1. Immunologic: susceptibility to measles, poliomyelitis, smallpox, diphtheria, pertussis, tetanus and other diseases.
2. Anatomic: lumps in the breast, obesity, lesions disclosed by chest x-ray examination, dysplasia and carcinoma-in-situ of the cervix uteri.
3. Chemical: elevated blood-glucose, cholesterol, triglycerides, uric acid, low hemoglobin, and proteinuria.

4. Physiologic: elevated blood pressure or intraocular tension, electrocardiographic abnormalities, and diminished respiratory capacity.
5. Behavioral: agitation, depression, cigarette smoking, excessive use of alcohol and other drugs.

Medical advances permitting surveillance over such items (and many more could be cited) now make it feasible to convert the whole health care system from a complaint-response focus to a health-maintenance focus. This would entail the assumption of responsibility for the health care of a defined population by an organization of physicians and other resources. Such a system would require periodic monitoring of the several parameters outlined above and prompt action to control any abnormalities found. It should be emphasized that the system would also provide appropriate response to symptoms whose significance the persons under health surveillance would be taught to appreciate and bring promptly to the physician for attention. The complaint-response element of health care would become a secondary, though, when needed, an urgent aspect of it.

Primary aim of the system would be to maintain health, with such specific objectives as reduction of measles, invasive cervical cancer, mortality from diabetes, coronary heart disease and lung cancer—all attainable with present knowledge. Breakdowns of present arrangements for health care are well illustrated by the incidence of measles in the United States during the years following the marketing of a vaccine against the disease, and by the occurrence of deaths from cancer of the cervix more than twenty years after the development of a highly effective diagnostic and therapeutic approach to the disease. Following a dramatic decline in the occurrence of measles during the mid-1960s when an effective vaccine became available, the incidence began to climb again during the late 1960s, and during the first twenty weeks of 1971 the occurrence of measles was almost twice as great as during the corresponding period of 1970. Also during the late 1960s and into the 1970s thousands of deaths from cervix cancer and tens of thousands of cases of invasive cancer of the cervix continued to occur in the United States each year, even though an effective diagnostic technique—the cytologic test—and effective treatment had been available for two decades.

In the health-maintenance system of health care, a physician would feel the same sense of shame upon the occurrence of a case of measles or

invasive cancer of the cervix, as he feels in the complaint-response system for missing an obvious case of appendicitis.

This reorientation of health care has become possible only in the last decade or two with the scientific, technical and organizational developments typified by vaccines for poliomyelitis, measles and other diseases; means for controlling vascular hypertension; the cytologic test for cancer; automation of blood-chemistry procedures; and multiphasic screening. New promising techniques are continually being tested—for example, now, breast cancer detection by x-ray. Realization of the full health potential represented by these advances will not come with the present, essentially slipshod arrangements for health care. It will come only with deliberate organization of health care resources directed toward the goal of health maintenance.

Although the latter is set forth here as the primary basis, attention must also be given to other considerations in the organization of health care. From the standpoint of the consumer, health care should not only be directed toward the fundamental goal of maintaining health; it should also be accessible, comprehensive and of good quality.

As pointed out by President Nixon (and others before him) many persons in our society simply do not have access to health care. This is true of persons isolated from it by reasons of geography (rural people), poverty (the poor), ethnicity (blacks and Chicanos) and inadequate transportation (inner-city urbanites). Assuring access to care is an elementary, but often neglected, principle in moves and proposals to improve the organization of health care.

Another goal in the organization of health care is comprehensiveness. Too frequently after an individual gains access to health care he finds that present arrangements make it highly fragmented. Health care is often available only as disconnected bits that the patient must somehow put together—a physician for his chest, another physician in a different office and perhaps some distance away for his feet, still another place for laboratory or x-ray diagnostic service and so on. It would be far preferable, obviously, for the various services to be arranged so that comprehensive care is facilitated. Once the person enters the health care system, he should find the several elements (preventive, diagnostic, therapeutic, rehabilitative) organized in a fashion that promotes continuity. In recent years some movement has been made toward comprehensive and continuous care, both in formal aggregations of physicians and in informal ones, but the fact is that health service for most Americans is still highly fragmented.

Quality is another important aspect of health care, and not as esoteric as many physicians and others imply. Several specific means of evaluating it are gaining acceptance. One is measurement of outcome: are infant mortality, communicable disease rate, and survival from cancer better under one system of health care delivery or another, given comparable populations and other features necessary for such evaluation? A second approach to evaluating the quality of health care is to examine the structure of health care—i.e. the extent to which both the institutional and professional providers conform to a high standard. For example, do the laboratories participate in approved proficiency testing programs? Is the surgery performed by qualified personnel? Are the hospitals accredited? The intent of these structural safeguards in health care is to maximize the likelihood of a desirable effect and minimize the likelihood of a harmful effect or superfluous care. Third, one may compare the actual process of care in different systems, for example, by examining the medical records to determine whether patients with selected conditions obtain services in conformity with standards established by experts. Such a medical audit can disclose whether pregnant women receive urinalysis, Rh determination and all the procedures deemed necessary for good prenatal care.

Among the bases for the organization of health care, then, it is desirable and feasible to include both a system goal (health maintenance) and such features as access, comprehensiveness and quality.

A Model for the Organization of Personal Health Services

Considering the nature of the need for organization of health care and the goals to be achieved by such organization, it appears that attention at the present time should go first to primary care and then to the network of services that back up primary care.

Primary care, as used here, consists of all the services that can be provided on an ambulatory basis, close to where people live (or work), that are aimed primarily at health maintenance and will be fully adequate for eighty to ninety per cent of the problems brought to physicians in the form of complaints. Primary care of this type can probably best be provided by small teams of physicians and allied health workers carrying responsibility for the persons and families in a defined population. Each

primary health care team would know these persons and families and be dedicated to their health maintenance. This sense of responsibility would renew something that has been lost in much current health care, but that is still desirable, a true patient-physician relationship. Despite the fact that it has become fashionable in some circles to express disdain for that aspect of health care, confidence in one's physician can probably never be superseded entirely by the technology of medical science. A considerable amount of consumer frustration with present-day health care appears to arise from not knowing a health professional who really cares.

The primary health care team would consist of three to five physicians and a dentist or two, along with nurses, assistants, technicians and other personnel capable of providing primary care to 4,000–6,000 persons. The physicians would be the new type of family physician being trained at present, or general practitioners, internists and pediatricians of the type trained in the past but reoriented to family practice. Each person would relate to a particular physician, but understand that alternate members of the team would also serve him.

Several primary health care teams might be located in one health center and be supplemented there as needed by certain other commonly needed health personnel—for example, obstetricians, surgeons, laboratory workers, records personnel and optometrists. Such a health center could thus provide primary care to 20,000–30,000 persons. Primary health care teams, whether located in health centers or not, would extend into the community they served through home-visiting personnel: public health nurses, “outreach workers” and others. They would be closely related also to other resources that support health such as sanitarians, social welfare personnel and the specialized agencies that have sprung up to supplement the mainstream of health care.

Groups of primary health care teams would link their services with community hospitals where both outpatient and inpatient specialty service would be available for those situations that are beyond the technical competence of those in the primary health care teams. Close relations would be maintained between the hospital and the several primary health care teams for whose patients specialty service was being provided at the hospital.

Beyond the community hospital and serving as support for several hospitals, each with its group of primary health care teams, in a regional network, would be the health science center. The latter typically would

be associated with a medical school and possibly other health science schools having responsibility for education of health care personnel; for health science research and for providing the most highly specialized and newest technical services to all persons in the area served by the several community hospitals and their associated primary health care teams.

The health science centers would have another key mission, besides the traditional triumvirate of education, research and service incidental thereto. That mission would be to improve the quality of health care throughout the area. The centers would carry out this task not only by continuing education designed to reach all health workers practicing in the area but also by developing and evaluating new (and, hopefully, better) methods of organizing health care. This responsibility would require the health science centers to assume active leadership of the entire health services network in the area. It would also be desirable for the health science centers to operate for demonstration and study purposes a primary ambulatory care service and a community hospital service, both probably on a small scale.

In this health services network the organizational focus would be on primary ambulatory care as the point of:

1. access by all persons to the health service system;
2. physician and team responsibility for health maintenance through regular surveillance of the several parameters important thereto, and action to correct deviations from the norm;
3. response to most symptoms, as well as for referral to more highly specialized service if needed;
4. planning for comprehensive service for each person in the community.

This arrangement directs emphasis away from the hospital, heretofore the most highly organized and institutionalized aspect of American health care; it places emphasis upon a team of health workers capable, when linked with hospitals, of bringing modern health care systematically into the community. Such a regional network of health services, if coupled with adequate financial mechanisms, would provide access for all persons to comprehensive, high-quality health services, with emphasis on health maintenance.

Steps toward Improved Organization of Personal Health Services

Evolution of health care delivery from the present situation toward some such model as the above (alternatives should obviously be kept open and actively explored) will probably proceed through a series of steps, linked with new arrangements to finance health care. Hopefully progress will be somewhat orderly, but not without some fits and starts into blind alleys. The latter constitute the price of flexibility and adjustment of the model in the course of experience with it—"feedback," in the lingo of the operations researchers. The American style in such matters is to maintain the options, encourage innovation and avoid a national mandate for a particular model.

Several things are needed, however, for the evolution of better health care delivery.

Obviously high on the list is a national commitment to develop a better health care delivery system. One might assume from the language and the sources cited at the beginning of this paper that we have such a national commitment. Unfortunately, that would be a false assumption. Vigorous rhetoric followed by no action or minuscule action has become so commonplace recently in the health field that one simply cannot place much confidence in statements of intent. True commitment will come probably in the form of national legislation to make comprehensive health care equally available to all persons as a social right, and sufficient funds for health resources development—personnel, facilities and organization—to guarantee that right.

Until that time, continuing what has already started on a small scale in the past few years and expecting vast acceleration with a national commitment to comprehensive health care for all persons, we can proceed with development and testing of individual elements that will ultimately be integrated into a total system.

Among these elements is the new medical specialty, family practice. Within two years of the latter's establishment and recognition by the American Board of Medical Specialties, more than fifty family practice residency training programs have been approved and many more are being developed. The physician who receives training in family medicine should be capable of providing primary care and relating effectively to the entire health service network, as described above. One of the most promising recent developments in medical education, this specialty

training in family medicine is still in an early phase and not yet well understood. It may lead, however, to preparation of a key element in the projected model of health service, namely, a physician trained for modern primary care.

Another element is the health center. This has taken a variety of forms during the past 25 years: facilities of the group practice prepayment organizations, such as the hospital-based Kaiser health centers and freestanding health centers of the Health Insurance Plan of Greater New York (HIP); health department clinics offering expanded "preventive" services; neighborhood health centers sponsored by the Office of Economic Opportunity in communities composed predominantly of poor people; field clinics for migrant farm workers and their families; "free clinics" for young people served by volunteer professionals; and others. These new forms of ambulatory health service are increasing in number and variety. A common thread is the organization of primary care based on a group of physicians and some allied health workers, and usually involving a deliberate attempt to adapt the service to community needs. More and more Americans seem to be seeking organized primary care, even that offered by "emergency" services at hospitals, rather than depending upon individual physicians. The situation thus appears ripe for promotion and support of health facilities, with their presently varied names, styles and sponsorship, that could become primary health care centers oriented toward health maintenance and thus constitute an important element in the improved organization of health care.

With few exceptions, such as Kaiser and some other hospital-connected health service organizations, the health centers developed in recent years have not yet been very effective in linking their primary care with specialty outpatient and inpatient care when the latter is needed. Even though ad hoc, tenuous arrangements are the prevailing pattern, the idea of a definite regional health network, one that could provide truly comprehensive care, does seem to be taking hold. The Hill-Burton program for hospital planning and construction, the "regional cooperative arrangements" fostered by the Regional Medical Programs, Comprehensive Health Planning with its area-wide focus, recent efforts by medical schools to get out into the community, and the recent OEO move to support regional health networks rather than freestanding neighborhood health centers—all these exemplify application of the regionalization idea. Although individually these steps have apparently made little impact, as a whole they are encouraging persons in

the health field to think more about linkages between health facilities as a means of improving the organization of services. Here and there a few definite moves can be noted: consolidation of maternity services and pediatric services in a few metropolitan hospitals, rather than having these services diffused through all hospitals; sponsorship of OEO neighborhood health centers by medical schools that back up the new services with the full range of medical care; agreements by community hospitals and health departments to furnish necessary laboratory and specialty support to "free clinics"; and contracts by state Medicaid agencies to health care organizations that undertake to provide a fairly complete range of benefits, from primary care through hospital care.

During the past few years, while public attention in the health field was being directed mainly toward the financial aspects, and the sophisticates were analyzing the organizational deficiencies, some real development of elements has resulted that could ultimately fit into a better organized system of health care: family practice as a specialty of medicine; health centers adapted to various life-styles in our country—middle class, poor, hippie, migrant farm family; and even small steps toward regional health networks.

What is needed is (1) support for the start-up costs of these and other steps that will lead to improved organization of health care, on a scale such that only the federal government can undertake; and (2) substantial incentives toward improved organization in the way providers are paid for care. It is, of course, discouraging to find bold analyses of the problem by national leaders followed by proposals to revamp the system with ridiculously small amounts of money, at the same time incorporating into the payment mechanism proposals for incentives in the form of billions of dollars to keep the "system" operating the way it has been.

To effect change in health care delivery within a reasonable period of time will require both substantial funds for the necessary resources and organization, and substantial incentives to attract physicians and other health care personnel into the forms of organization desired. One cannot ignore the close interrelation between the financing and reimbursement arrangements and the need to improve the organization of health care. If the plan for financing, for example, entails two funds, one for the poor and one for the more affluent, experience has painfully demonstrated that the organizational result is two systems of care. One of the latter typically is a local public hospital and clinic system for the poor, which is deteriorating rapidly these days.

Another key element is greater consumer participation in policy formulation and governance of the health care system and its components. Providers have been in firm control of the health care system, its assets and its services. Their decisions as to location, nature and other aspects of the services offered have been guided largely by rather narrow self-interest rather than the public interest. The current rise of consumerism in America is beginning to have some influence, for example, in changing membership of Blue Cross boards, but the health system would no doubt benefit from a considerable expansion of consumer participation at every level: institution, community, region, state and national. As John Dewey pointed out:¹¹

No matter how ignorant any person is, there is one thing he knows better than anybody else, and that is where the shoes pinch his own feet, and that is because it is the individual that knows his own troubles, even if he is not literate or sophisticated in other respects. The idea of democracy as opposed to any conception of aristocracy is that every individual must be consulted in such a way, actively not passively, that he himself becomes a part of the process of authority, of the process of social control; that his needs and wants have a chance to be registered where they count in determining social policy.

Evolution of present arrangements for health care into a more desirable pattern appears to be much needed and some moves are in fact under way. There even seems to be considerable agreement on the general direction if not on some ultimate model. It now would be timely to substantially increase the funds for demonstration and testing of the several elements that must fit into a better system, and for linking up these elements into networks that show promise of accomplishing the objectives desired in health care. New federally supported programs of health care and revision of some current programs, furthermore, should include substantial incentives to providers to organize better health care.

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