# BOOK REVIEWS

## HEALTH CARE FOR THE COMMUNITY

Selected Papers of Dr. John B. Grant.
With a Preface by Dr. Cecil C. Sheps

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John B. Grant came of a Canadian missionary family and was born in China in 1890. From school in Nova Scotia he went to Ann Arbor; and in 1921, a year after finishing his graduate studies at Johns Hopkins, he was sent by the Rockefeller Foundation to the Peking Union Medical College. A member of the staff of the Rockefeller Foundation for forty-two years, he had long periods of executive work—in China, in India, and, from 1955 until his death in 1962, as professor of public health and medical care in the University of Puerto Rico. But, though his world was the world of action, his more lasting contribution to medicine was as a thinker. His collected papers, ably edited by Conrad Seipp, are not always easy reading, but they are those of a man whose reputation will go on growing.

Most remarkable, perhaps, is the consistency of what he wrote: the policies and programs of a long life were nearly all elaborations of the same related themes.

Some forty years ago he recognized three principles for the prac-

tice of medical care. First, he noted that progress in health is proportional to progress elsewhere—"public health cannot progress beyond the effectiveness of education; agriculture beyond communications." Secondly, preparation for health work in the community must be through participation, which means that, if medical education is to be reoriented to prevention, every teaching hospital must have a field practice area—a social laboratory—under its own control. Thirdly, the full benefit of medical knowledge and care is obtainable only by regional organization.

"Community health care" seemed to Grant a less narrow term than "public health." The personal services, whose aim is to protect, promote, and restore the health of individuals, are part of a spectrum which has environmental services at one end and educational services at the other. Especially when resources are limited, the initiative and capabilities of the people must be enlisted for self-help; but even in advanced countries the quality of medical care depends on the public's using the technical services wisely. A backward community must be shown its needs; but, unless there are also ways of meeting them, the result will be frustration and social instability. For improving low standards, a "quality demonstration" is required. The hospital, for its part, must extend itself into the community, as a means of increasing the "technical consciousness" of the public. And the community should have a health center whose doctors have extended their practice from the clinical to the social, and have come to regard the family as their unit.

At present medical education does not produce the doctors needed for such centers. The student ought to learn by "seeing and doing" as well as by "reading and learning"; and, just as the teaching hospital has provided laboratories for the basic scientists and pathologists and clinics for the clinicians, so it must now provide social laboratories for training, service, and research. The changes from reorienting medical education toward prevention are likely to be as profound as those that followed the Flexner report in 1910. A "core" curriculum with three components—the basic sciences, the clinical sciences, and the health sciences—will be a foundation for postgraduate training in any of these branches.

Besides providing specific instruction, the teaching department of public health has to see that its subject so permeates the curriculum that the future practitioner can be the family adviser in preventive medicine. Health education, Grant said, is not just an additional paramedical activity to be undertaken by health educators: it is the duty of every physician, nurse, or other health worker who deals directly with a patient. The product of our present medical education "generally lacks even consideration of the patient as a person much less as a member of a family or the community." And, if the distribution of medical care is to be properly balanced, the people at the top must be health-minded rather than disease-minded; otherwise public hospitals will have an uncontrolled vested interest in curative medicine.

The regional organization of medical care, with which Grant's name is so closely identified, implies centralization of direction but progressive decentralization of activity—with co-ordination at various levels and a two-way flow of information and ideas. Grant saw the teaching hospital as the regional base hospital for a group of community health centers and community hospitals, providing them with diagnostic and consultative services and taking responsibility for the continuing education of the professional staffs. "Regionalization corrects the present defect of hazardous unrelated hospital factilities"; indeed, an independent and autonomous hospital facility is now an anachronism. The lower a country's economic level, the more its use of medical knowledge depends on organization; but regionalization is the basic principle of planning in developed as well as in undeveloped areas. Grant observed that, four decades after regionalization was proposed in the Dawson report in Great Britain, it had still not been comprehensively introduced in any democratic country. Thanks largely to the work of his last years, Puerto Rico may soon provide an impressive demonstration. In the long run, he believed, even the richer countries will cease to tolerate the waste inseparable from inco-ordination.

In the United States, he said, the separation of preventive and curative medicine is almost a fetish, and this attitude has hindered progress in less developed countries to which it has been exported.

Indeed health care services in the United States, both public and private, "continue to exhibit a greater lack of coordination than is found anywhere else in the world." The ultimate goal of the Hill-Burton Act of 1946 was regionalization. The preamble of this law was an advanced statement of public policy; but the objectives set remain largely unfulfilled. "Responsibility for the coordination of health services"—wrote Grant characteristically—"cannot be effectively discharged if it is left to one of the services being coordinated"; and he insisted that each regional office under the Act must have its own budget. In any country, he thought, "there should be an over-all national plan for the financing of health care," although the funds may come from multiple sources; and expenditure on health care should be in accordance with the plan rather than through the channels by which the money has come.

For Grant, analysis and synthesis were not enough: he was the kind of thinker who wants to see whether his ideas work. Kindly but indomitable, he had a singleness of purpose that rarely goes with so much common sense. Though his aim was the improvement of social services, he saw these not as an end in themselves but as a means to a good life. He was a prophet aware of his world; and, though some of his prophecies may now sound commonplace, the hard thinking of forty years has produced, for health care, a code which is at once coherent, wise, and translatable into action.

Dr. Cecil Sheps recalls a remark of Grant's: "When setting up a program, set it up so that twenty-five years hence it will still be progressive." Most of the policies in this book are going to look progressive for longer than that.

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