# DELIVERY OF PERSONAL HEALTH SERVICES AND MEDICAL SERVICES FOR THE POOR

## Concessions or Prerogatives

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### WHAT ARE PERSONAL HEALTH NEEDS?

Bessie Smith, of the "Death of Bessie Smith," by Edward Albee, died outside of a Mississippi Hospital that would not admit her. In 1966, that same hospital would admit her, but would not deliver or immunize her children, or treat her emotional crisis. In the urban north, Bessie Smith's poor cousin might be immunized at a public facility, but would be refused treatment. The facility that might treat her illness would refuse to immunize her. In Los Angeles, if she lived in Watts, she would travel two hours and spend $1.95 to get part of this care. In New York City, the travel time would be less, the waiting time as long and the impersonality of care and just plain rudeness would be equally great.

Such is the state of health services for the poor. For the most part, existing systems of care are inadequate, and it does not seem possible for them to be adapted to provide personal health care for the poor. Development of a new, more adequate pattern, however, requires review of the dimensions of personal care to be delivered to people, particularly since much of medical science to be delivered has been discovered recently and since new techniques of dealing with poverty and its social problems are being evolved. A rational consideration of the dimensions of the needs of patients and a possibility of meeting these with existing knowledge and manpower might lead to answers not otherwise apparent.

In considering patient needs, and throughout the remainder of this paper, distinction is made between *organic disease, psychiatric* and *social problems.* It is, of course, an arbitrary distinction and is used

because, in fact, such distinctions are used in clinical practice. In addition, a broad approach to the patient is emphasized, which would include consideration of all these elements, as well as simple politeness, human warmth or consideration such as might enter into any social transaction. These, of course, cannot be completely separated from psychotherapeutic considerations, but for the purposes of this paper, they are. Professional personnel may be inadequate to deliver all scientific knowledge, but it is certainly possible to introduce kindness and courtesy into transactions between the health establishment and the poor.

*Organic Diseases*

It is surprisingly difficult to estimate how much organic disease a front-line personal physician might reasonably be asked to treat. Studies of the Commission on Chronic Illness in Baltimore show a rate of chronic illness of 1,566.5 per thousand people. Twelve per cent of these illnesses were considered severe and 50 per cent substantial.[1] Descriptions of general practice in the American or English literature, however, do not indicate this amount of disease. Table 1, showing a sample of chronic conditions found in general practice, is illustrative.

The only figures reported from actual practice that approach the reported prevalence rates of the Commission on Chronic Illness are those reported from a study of New York internists,[2] which suggest that more

TABLE I. CHRONIC ILLNESS

| *Condition* | *Number of Cases* |
|---|---|
| Chronic arthritis (all forms) | 200 |
| Chronic emotional illness | 60 |
| Chronic bronchitis | 50 |
| Hypertension | 35 |
| Asthma | 25 |
| Peptic ulcer | 25 |
| Stroke | 15 |
| Rheumatoid arthritis | 12 |
| Epilepsy | 10 |
| Diabetes mellitus | 10 |
| Pulmonary tuberculosis | 5 |
| Pernicious anemia | 5 |
| Parkinsonism | 3 |
| Multiple sclerosis | 2 |
| Mental deficiency | 2 |

*Source:* Last, J. M., Logan, R. L. F., Fry, J., MORBIDITY STATISTICS IN GENERAL PRACTICE, London, G. R. O., in three volumes to be published.

TABLE 2. ESTIMATE OF UNDIAGNOSED DISEASE PRESENT PER 2,500 PERSONS

| *Condition* | *Number of Cases* |
|---|---|
| Chronic bronchitis | 200 |
| Anemia | 200 |
| Staphylococcal, nasal carriers | 200 |
| Hypertension | 120 |
| Depression | 120 (6 will attempt suicide) |
| Bacteruria | 100 |
| Obesity | 60 |
| Diabetes | 12 |
| Cancer of cervix, cervical smears annually | 2–3 positive |
| Pulmonary tuberculosis | 2 (to be assessed) |
| Cancer of lung | 1 picked up every two years |

*Source:* REPORTS FROM GENERAL PRACTICE: II. PRESENT STATE AND FUTURE NEEDS, London, College of General Practitioners, July, 1965.

pathologic conditions exist than are commonly diagnosed in general practice. Table 2 presents estimates of that undiscovered disease.

Further study of prevalence figures reported from such studies as that of the Commission on Chronic Illness and other studies of routine examinations shows that the diagnoses are those that a physician would find and list if he could leisurely contemplate a patient. The average internist or general practitioner in middle-income practice would find it relevant to his skills to list fewer than half of these, if indeed he had the time to do it.

Evidence indicates that the actual sorting is not based on rational priorities. For example, the author's studies of groups in the Health Insurance Plan of Greater New York (HIP groups) show that the groups with better-trained family physicians list a higher prevalence of serious and rare disease than do those groups with more poorly trained family physicians. Studies of general practitioners applying for positions in HIP showed many who had never diagnosed any of the common, but complex medical problems, such as valvular heart disease, anemias or hypertension. All groups in HIP have competent specialists; the difference is the competency of the front-line physician.

With better training, a physician will diagnose more serious disease and with more time, more conditions. Evidence suggests that a poorly trained or scientifically deteriorated physician cannot function well as a front-line physician. Yet most evidence, to be discussed later, shows that the skills of solo-practice, front-line practitioners do deteriorate and

that physicians have great concern about the probability of loss of their own skills.

In addition, in the Baltimore study,[3] 405 of all substantial chronic diseases were considered to be preventable in the sense that their progression could have been retarded. But very few front-line physicians are attentive to prevention. Well-worked-out techniques such as glaucoma screening and cervical cytology are not used substantially by practitioners and the former is not even taught in most medical schools. A large gap exists between what physicians could do if they have the knowledge, time or interest, and what some planners could hope to have done, since carrying out preventive planning for a patient requires a leisurely approach to the patient, inconsistent with the present supply of professionals.

Indeed, Sheps feels that prevention as a point of view cannot co-exist with the pressure of acute clinical activities.[4] The lack of interest in most preventive procedures by clinicians would seem to bear this out, and English practitioners seem to be even more resistant to preventive procedures than American doctors. It does not seem, at this point in scientific development, that substantial emphasis on prevention can be built into the activities of the front-line practitioner, except preventing the progression of diseases under treatment.

*Psychiatric Disorder*

The amount of psychiatric disease in a population seems also to vary with the eyes of the beholder. The highest figures are those revealed in the Midtown Manhattan Study, which showed 23.45 per cent of the population to be impaired. That included 13.2 per cent with marked symptom formation, 7.5 per cent with severe symptom formation and 2.7 per cent incapacitated. In addition, 58.1 per cent, although said to be carrying out their adult responsibilities well, were displaying varying "significant loads of pathology-denoting symptoms."[5]

The study in Baltimore showed 108.6 cases of psychiatric disorder per 1,000 people and 4.3 diagnoses per 1,000 people,[6] while the study of New York internists showed that 9.6 per cent new patients and 5.3 per cent of patients under continuing care had as their major diagnoses mental, psychoneurotic and personality disorders.[7] Clute shows a rate of 2.5 per cent per 100 visits in Nova Scotia and 3.2 per 100 visits in Ontario for psychoneurosis,[8] while the English studies of general practice show a rate of less than five per cent. Silver's studies, in which families seemed to get worse psychiatrically when followed intensively,

suggest that it is necessary to become thoroughly acquainted with the population to discover how much psychiatric pathology really exists.

Physicians feel that psychiatric disorder is widespread in practice, perhaps approaching the amount shown in the Midtown Manhattan studies. However, it is rarely labeled as such by the physician in his records and is obscured in the record by diagnoses focusing on the physical problems of the patient. The physician does that to keep the situation manageable in terms of his time and skills.

One then finds that, as is the case with organic disease, only a part of the psychiatric disorder actually present is usually diagnosed in practice, probably largely because of lack of time. Again, no good evidence is available to indicate either that valid priorities are used in deciding what the physicians should consider significant, or that people would be benefitted if physicians did diagnose more.

*Social Problems*

Any precise delineation of the extent to which patients have social problems is clearly impossible, and the situation is made more difficult by the fact that a problem could be defined as social or psychiatric, depending on the view of the observer.

Jeffreys attempted to gather some data on incidence of social problems, as shown in Table 3, but she reports that her staff were often struck by the physicians' detailed knowledge of the family circumstances of patients they believed had social difficulties and their comparatively limited information on other patients. She concluded that doctors became familiar with social problems only if they were directly confronted with their effects,[9] suggesting that, like organic disease and psychiatric problems, the physician limits his perception of problems because of lack of time and insufficient training.

However, when one turns to the care of the poor, most physicians feel that almost all patients have social problems. In most instances, physicians feel that the social problems are the patients' central problems, either because their importance outweighs any physical disease, or because they seriously interfere with the treatment of the disease.[10]

At the Gouverneur Ambulatory Care Unit, where 20 per cent of patients are on public assistance and another 30 per cent live at or below the financial level of public assistance, this centrality of the social problem, if one gets to know the patient, has become quite clear. The loneliness of the older poor in the community and their virtually complete social isolation in the nursing home staffed by Gouverneur is

TABLE 3. REPORTING OF SOCIAL PROBLEMS BY GENERAL PRACTITIONERS

| *Description of Problem* | *Number of Patients* | *Rate per 1,000 Consulting Patients* | *Percentage of Problems* |
|---|---|---|---|
| Disturbed social functioning due to mental illness or subnormality | 181 | 134 | 32.1 |
| Adjustment to chronic illness or disability | 76 | 56 | 13.5 |
| Marital relationships, sex in marriage, infertility or family planning | 73 | 54 | 13.0 |
| Care of the elderly, including domestic help, loneliness of housing (excluding inadequate means) | 71 | 53 | 12.5 |
| Child behavior in pre-adolescents | 38 | 28 | 6.7 |
| Social incompetence or antisocial behavior of an adult, including child neglect, low domestic standards, delinquency | 33 | 24 | 5.8 |
| Sexual problems in adults outside marriage, illegitimacy, homosexuality | 27 | 20 | 4.8 |
| Housing problems (other than for old) | 24 | 18 | 4.3 |
| Inadequate means | 20 | 15 | 3.5 |
| Adolescent behavior problems (excluding illegitimacy) | 11 | 8 | 1.9 |
| Social resettlement of immigrants | 7 | 5 | 1.2 |
| Other | 5 | 4 | 0.9 |
| Total | 566 | 419 | 100.2 |

*Source:* Jeffreys, M., AN ANATOMY OF SOCIAL WELFARE SERVICES. London, Michael Joseph, p. 382.

viewed by the staff as a more substantial problem than any organic disease. The obstetricians report that, in contrast to their private patients, the majority of mothers are unhappy when told they are pregnant. The unit estimates that one-third to one-half of its patients are illiterate in any language, and pediatricians worry far more about school dropouts and glue sniffing than meningitis.

### *The Health Needs of Patients: A Summary*

In looking at the health needs a front-line physician might be asked to meet, it is clear that more organic disease, psychiatric disorder and social problems exist than he has the time or skills to treat. The more time he spends with patients, the more organic disease, psychiatric disorder and social problems he will find. However, of the diseases he is

equipped by training to treat, he sees too few to enable him to retain the competence appropriate to a physician, at least as the present medical status system defines physician competency. How the varying systems of personal health care deal with this problem warrants exploration.

## EXISTING MODELS FOR DELIVERY OF CARE

### *Solo Practice or Practice in Small Groups*

Solo practice, or practice in small groups, is the most common kind of practice in this country, and, outside of large urban areas, it is almost all of practice. In terms of overhead or nonprofessional costs, it is the most efficient form. Theory to the contrary, it generally has a lower overhead than other kinds of practice arrangements. Physicians work longer hours, see more patients and cope with a broader range of problems. Indeed, with the present supply of physicians and without new forms of delivery, medical care could not be delivered in this country without the incentive of piecework payment that fee-for-service provides.

Both physicians and patients seem to prefer solo fee-for-service practice at this time. The desire of physicians for this form of practice is due largely to the lack of an alternative form that is professionally more satisfactory, and only in part to the large incomes earned in private practice. Patients seem to prefer that kind of practice because it seems to give more personal care.

A good case could be made for this method of delivery of care if it were not that several studies have shown serious deficiencies in its quality. In addition, fee-for-service practice in low-income neighborhoods, which private physicians are increasingly abandoning, is apt to be of low quality. Peterson in North Carolina found that 39 of 88 physicians studied were practicing at an unsatisfactory level,[11] seeming to lack fundamental clinical medical knowledge and skill. "Some physicians were not challenged by the practice of medicine. They appeared to lack zest for the practice of medicine, which had become a chore for them."[12] Clute, in his study of Ontario and Nova Scotia physicians, had similar findings. "Fifty-one per cent of the Ontario sample and 25 per cent of the Nova Scotia sample were practicing medicine of a satisfactory quality. It appeared that the deficiencies of these men were not likely to have serious consequences for their patients."[13] The deficiencies of the other physicians could have serious consequences for patients, and other studies have shown similar deficiencies.[14] Studies of over 300 physicians applying for practice in HIP, undoubtedly representing a sample of

New York City's more poorly equipped physicians, show similar findings to those of Peterson and Clute.

The fact that internists and pediatricians will be the family physicians of the near future might seem to offer a solution to the problem of quality in that those physicians will be better prepared and concerned with a narrower range of disease. However, the limited observations concerning internists as front-line physicians indicate a pattern of deterioration in some internists not dissimilar to that seen in general practitioners. Because front-line internists must see too many patients with more problems than they can manage and too little of "their kind of disease," their additional training *per se* will not prevent scientific deterioration. Internists themselves report that their training is not properly used in family practice.[15]

Despite its advantages, solo private practice must be rejected as a way of delivering personal care in the future, because it cannot keep up with scientific progress. To expand it now would not help the poor.

*Prepaid Group Practice*

Prepaid group practice as an organizational form is probably midway between private practice and hospital and health department-connected practice in quality of care and delivery of personal care. It is similar to the hospital and health department-connected practice in that it is organized and tends to use specialists and laboratory and x-ray services, and it is similar to private practice in that it does not serve the poor, and has economic incentives for physicians. Mechanisms for correcting the defects in quality described under solo practice are present in prepaid group practice, but whether its quality is better than other types of community care has not been subjected to comparative study.

The question of physicians' productivity when paid by salary as opposed to piecework is a subject that also needs more study. Although some of the group practice plans do not have any income-sharing plan, the larger ones do. Some plans without these incentives have been considering adding them in an effort to increase physicians' activity and to induce physicians to take a more personal interest in patients.[16]

The staffing pattern in the prepaid group practice units as a solution to health manpower shortages in the delivery of health services to the poor is more apparent than real. Experience of the Health Insurance Plan shows that the poor require much higher staffing ratios than do middle-class clients, even as the plans define the needs of these patients,

and the comprehensive group practice plans may be comprehensive only in terms of the clients they serve, or as seen by the plan itself. Most prepaid plans provide for the common specialties, but do not provide as extensively as do hospital-connected clinics for subspecialties. Also, these programs make limited provision for treatment of psychiatric and social problems, perhaps because these are less obvious in their middle-class clients, or because they interfere less with treatment of organic illness in middle-class clients. Lack of such provision might also be simply a reflection of the interference with the economic incentives of the plans that favor using physicians' services. These plans tend to use ancillary personnel, such as nurses or nutritionists, less than government or hospital-organized services, but more than private practice.

In short, these plans do not have the professional resources to provide personal care for the poor, and building in the services necessary for the poor would make them too expensive for the middle-class or interfere too much with the plans' economic incentives for physicians. The plans are also too isolated from the social utilities of a community to use these utilities effectively.

*Hospital and Health Department: Connected Practice*

Hospital and health department-connected practice can be grouped together because of certain similarities. Both represent practice as health professionals would set it up if they did not have to respond to patients' desires as they do in private practice. In this kind of practice, care is generally disease centered and fragmented. No attempt is made for any practitioner to serve as a general or family physician. No significant effort is put forth to respond to anything but organic or preventable disease. This fragmentation is usually justified as necessary to provide high-quality care and would seem to reflect the practicing clinician's knowledge of how poor the quality of care is in solo practice. At the Hartford Conference on Ambulatory Care, however, the panelists agreed that one of the reasons for the present fragmentation of hospital-connected services was the desire of the physician to avoid getting to know the patient and having to come to grips with his social problems.

These facilities provide most of the care given to the poor in urban areas, but they discourage use through unpleasant surroundings, cold personnel and scheduling made without regard to patient's needs or desires. As one director of medicine in a New York City hospital said, "These are doctors' clinics. Someday we may have people's clinics."

Indeed the clinics are organized to serve the needs of the physician for education and research, and they reflect the status system of medicine when economics is removed.

The majority of other health professionals of the "non doctor group," such as social workers, public health nurses and nutritionists, are participants in this kind of care. Clinic plans developed by physicians as a rule envision the use of other health professionals, though the same physicians might not use them in their own private practices; such health professionals are not used in middle-income practice because they are too expensive per service, more expensive per service than the physician, though they do a better job with certain problems. Most clinics also make extensive use of laboratory and x-ray facilities. Hospitals and medical schools have little difficulty employing physicians to work in these settings because they provide mechanisms for the physician to retain his competency.

Rarely in the clinics is any authority concentrated in any person, allowing him to pull the fragments together to form a coherent pattern for patients or to respond to demands of government or other agencies that it be done. Authority is dispersed among the chiefs of various services, who often delegate it to many subspecialty chiefs. If a person is designated as director of ambulatory services, it is most unusual for him to have any authority to coordinate services fully. Indeed, it is generally difficult to find mechanisms for making over-all decisions.

New York City's Health Department illustrates the problem. Since the 1930's, the bureau chiefs in the central office, who are analogous to a chief of service in a hospital, have conflicted with the local health officers, who serve as medical care generalists. It would be difficult to integrate child health services in New York City in any district, since school health, well-child care and nursing are directed by separate bureau chiefs, a problem entirely analogous to the difficulties in integrating hospital ambulatory services.

The lack of overall authority and the resultant inability to obtain social accountability is a defect of such magnitude that it supports the view that present hospital clinics cannot be salvaged to provide any kind of personal care that is socially accountable. Almost all major patient care projects in the country that have attracted attention are limited to one clinical specialty such as medicine or pediatrics, presumably because of the problem of coordinating these many areas of professional power. If specialization and many health personnel are needed to the extent that care organized by the professional would indicate, one possibility

for unification would be by direction of a medical care person who could be the generalist, at least in program conception. Yet this has not seemed to work out in any existing clinics.

The resources of hospital and health department-connected facilities should be built into any future system of health services for the poor, but adaptation for personal care may well be impossible and something entirely new may be required.

## THE PLAN FOR DELIVERY OF PERSONAL HEALTH SERVICES TO THE POOR

At a conference called by the Office of Economic Opportunity in 1965, the participants generally agreed that no existing model of care could be adapted to deliver personal health services to the poor. Since, for the most part, personal health services for the poor are nonexistent, development of a new model to fill that void must be considered.

The new model must utilize powerful noneconomic incentives not available to existing models, chief among which is the opportunity for a physician to practice rationally. Then such a plan must allow for changes in the dimensions of the problem of delivery of personal health services by such scientific and technological advances as a vaccine for common viral infections, a policy decision to extend the applicability of renal dialysis, or a new screening test for arteriosclerosis.

Society must be prepared to allocate more resources to health if it wishes to distribute personal services to the poor, for the methods of delivery are costly. Group practice will be more expensive than solo practice, the use of other health professionals will be more expensive than use of physicians, and the use of nonprofessionals more expensive than use of professionals. Physicians will cost more per patient served when paid by salary though the salary be lower than-fee-for-service incomes. But on the whole service may be better and at any rate, community action may not allow much choice.

### *The Case for Administration*

#### *Medical School and Medical Centers*

Medical schools and medical centers have the scientific resources of the present. They also represent stable institutions familiar to physicians, and association with these centers offers the opportunity for a physician to retain his professional competence. That is the only incentive that can compete with the financial rewards of private practice and

provides the only status that competes with that of private practice. Because of their power, medical schools would seem to be the force most capable of establishing new patterns of community health services.

Other reasons may be cited. The lessons of the past and the scientific hopes of the future indicate that the delivery of personal services must have close links to developing technology so that practice can change with the science of the time. Finally the obligation to meet the needs of patients might force a school to prepare practitioners who meet the needs of patients.

The present services for the poor that are administered by medical schools and by medical centers, though unadaptable for delivery of personal care, can be very useful as backup referral services, and mechanisms can be developed to insure that patients are dealt with courteously, and perhaps even kindly.

The services for delivery of care will have to be in the community to allow a proper blend of influence by the school and by the needs of the community.

### *The Case for Increasing Expenditures for Ambulatory Services*

The emergency rooms and clinics of the large urban hospitals will continue to be an important element in the care of the poor, the clinic being the caring source for the chronically ill and the emergency room for the acute episodes of the healthy poor.[17] As suggested earlier, if the plan in this paper were accepted, these would still be an important part of a medical care system.

The ambulatory care facilities, generally agreed to be inadequate, should be rapidly improved by better financing. Visiting these facilities in New York and in many other cities, one finds that they are for the most part uniformly unattractive, unpleasant and inefficient. An exception to this, in strong contrast to its ancient basement clinics, is the new emergency room of the Cincinnati General Hospital, and the facilities in smaller communities, which are not economically segregated as they are in the large urban hospitals, may also be excepted.

In general, benches and lack of the simpler amenities in ambulatory care facilities make waiting for services unpleasant. Most frequently, receptionists, clerks and aides represent the lowest segment of the labor market in calibre, presumably reflecting in part their low salaries and the calibre of personnel departments. Part of the waiting required is due not to inadequate professionals, however, but to inefficient physical

space and equipment. Physicians do not have space to examine patients in privacy, they call their own patients, often wheel patients themselves to the x-ray or laboratory and write out orders by hand. Handwritten records waste both the time of the physician in the writing and the time of the next physician in deciphering illegible, bulky charts.

In New York City, despite the high priority given to alleviating the acute shortage of nurses, approximately 25 per cent of public health nursing time in schools is wasted because the nurses do not have telephones.

No other industry would use such expensive personnel so inefficiently. But regardless of what changes might be created in health professionals, inadequate facilities and nonprofessional personnel will deter the poor from getting kindly and efficient care.

### *The Case for Unification of Social Welfare and Health Services*

Since physicians alone cannot meet all needs of the poor, their concentration on the diseases of the poor has probably been a rather rational use of their skills. But, awareness is increasing that treatment must be given not just for an individual, but for a social problem.[18] Unless the physician is backed up by the social welfare services necessary to do the job expected of him, he will find the task too frustrating or overwhelming to cope with and lacking in professional gratification.[19]

Jeffreys, after studying the social welfare services in a county in England, reached the conclusion that health and social utilities need to be united for maximum effectiveness of both. Table 4 shows the percentage of patients with problems requiring social welfare services found by Jeffreys to be receiving help from general practitioners. General practitioners made the largest number of referrals to the social welfare service in her study.[20] They were directly or indirectly helping approximately two-thirds of patients with problems, and one-third of their patients had social problems as the main complaint.

The greatest demand for both health and social welfare services exists in the very old and the very young. Sexual problems, illegitimacy, narcotic addiction, inadequate income are kinds of problems that require medical and social insights for management.[21] Evidence is appearing that the problem in "hard-core families" is a basic cognitive defect and until it has been ameliorated social rehabilitation of the family is not feasible. Some of the most important advances for the poor may come from a synthesis of educational and psychiatric knowledge and this in-

TABLE 4. PERCENTAGE OF PATIENTS WITH DIFFERENT PROBLEMS WHO RECEIVED HELP FROM DOCTORS DIRECTLY OR INDIRECTLY

| *Type of Problem* | *Percentage of Patients Receiving Help From a Doctor* | *Number of Patients Consulting* |
|---|---|---|
| *Greater than Average* | | |
| Care of elderly | 83.1 | 71 |
| Social incompetence | 76.0 | 33 |
| Adjustment to disability | 75.0 | 76 |
| Mental health | 71.8 | 181 |
| Child behavior | 71.0 | 38 |
| All Types of Problems | 62.8 | 495 |
| *Less than Average* | | |
| Marital relations | 59.9 | 73 |
| Extramarital sexual behavior | 52.0 | 27 |
| Inadequate means | 50.0 | 20 |
| Social resettlement | 2* | 7 |
| Adolescence | 4* | 11 |
| Housing | 37.5 | 24 |

*Actual members.

*Source:* Jeffreys, M., AN ANATOMY OF SOCIAL WELFARE SERVICES, London, Michael Joseph, 1965, p. 118.

deed may prove to be one of the many keys needed to solve the problems of poverty. The Headstart Program of the Office of Economic Opportunity, conceived at a medical school and directed by a pediatrician, is an example of such collaboration.

The rather common suggestion that a physician should become a social scientist is not the proposal of this paper, however. Most evidence suggests physicians have enough to do in their present area of expertise. Rather the point is that in dealing with the problems of the poor, the physician must have ready access to the social utilities necessary for management of his patients. He must be able to prescribe and use these just as he does other specialists and laboratory studies. In fact, it is the absence of these utilities that has led the physician to flee the poor or to delimit his area of interest to that in which he possesses adequate resources, the treatment of disease.

Neither is this a plea for larger hospital social service departments, since these departments are not usually adapted to the needs of patients or to those of other health professionals. The hospital social service departments are often as inbred professionally and as isolated from the

community as are the medical scientists, Or, if working with the community, they are not of the community.

The newer technology, being developed by the demonstration health programs of the Office of Economic Opportunity, provides a basis for common action between health and social welfare workers, since an attempt is being made to develop the scientific insights to allow the use of social utilities in such a way that the poor may be freed from their dependence and social alienation. The Gouverneur program, made possible by a grant from the Office of Economic Opportunity, has from its inception attempted to integrate all health and welfare services. The new caring model for Gouverneur envisions a regular association between the health personnel and social welfare workers from the neighborhood to facilitate personalized intervention in the problems of patients. To date, that has consisted of joint involvement with many social agencies in projects.

To see whether public assistance can be adapted to aid social rehabilitation, or at least not impede it, the clinic is now operating a welfare center. The center attempts to alleviate the serious problem the clinic has in getting the eligible poor to accept public assistance. Under a joint grant with Mobilization for Youth, the neighborhood community action program, the clinic is also training unemployed people to be health visitors and patients' advocates, and the clinic is helping to support a group of welfare recipients who have organized to bargain for their rights. The Gouverneur health program will be joined with another settlement house in a joint effort in the most depressed area to reexamine both the basic roles of the various disciplines and the needs of patients, in an attempt to merge health and social services in a new way.

*Professional Roles in the Future*

Underlying the new professional roles in the future is the idea that medical care should be given by groups of health professionals linked to medical centers, but who are practicing in the community and have access to the social utilities of the community. A potential patient would relate to such a community-based unit as his health resource. At any given time he might have a personal relationship to a health professional, the one most relevant to his problems. Community pressure could insure that the facility was pleasant and the personnel at least courteous and hopefully, kind. Preventive measures would be carried out by administrative planning, using machines, technicians and community education. Many procedures, such as glaucoma screening

and topical application mammography can be carried out by non-professionals or by machines such as those being developed at Kaiser in San Francisco.[22] Immunization, well-baby care, prenatal care, for example, are probably better done by nurses than physicians. Significant preventive activities that must be carried out by general education or changes in society would include prevention of obesity, nutritional deficiencies, alcoholism, cigarette smoking, venereal disease and others. Finally, many patients would receive episodic, ad hoc care. The physician would treat "organic" disease and every effort would be made to help him retain his competence by limiting the activities not relevant to his competence.

Two types of professionals can take over some of the tasks now assigned to the physician.

The social worker and public health nurse are not too different anymore, and could be assigned the role of the generalist. Because of their short supply at this time, they should handle high-priority cases, patients or families with a high component of social, cognitive or psychologic problems. Dealing with these problems takes time and demands an approach more leisurely than that of the physician.

A second type of health assistant is exemplified by the optometrist, audiologist, midwife and podiatrist. That group would take over specific functions usually carried out by specialists. Optometry, for example, is essential for ophthalmology to exist as a specialty. Experience in the Health Insurance Plan of New York has shown that if an ophthalmologist provided all eye care for a population, he would not have time for enough surgery or treatment of serious disease to retain his competence, and in the true sense be an ophthalmologist.

Finally, a medical care generalist as administrator would mold together the many health disciplines and specialists so that the patient could have a semblance of a total program of services. The medical care generalist would be charged with making the program socially accountable. Generalists are in very short supply and indeed that is the most serious professional shortage at present. Barely enough are available to staff committees, make speeches and write papers, let alone do the work of directing community programs. It may be necessary to set up special training programs to create them.

## COMMUNITY ACTION AND HEALTH

The present system of delivery of health services to the poor in general is unsatisfactory, with services often of very poor quality and lacking in a personal continuity, or in many areas, no services at all except in the most serious emergency.

In an effort to improve the quality of fee-for-service practice, government or voluntary agencies have used medical schools and hospitals, but the services seem to have been organized by the professions more to meet their own needs rather than the needs of patients. Voluntary hospitals, ostensibly set up to serve the poor, have in actual practice been used by the classes that finance them as a means of providing the opportunity for their own physicians to retain professional competency. Personal physicians to the middle- and upper-income groups retain their expertise by being part-time impersonal practitioners to the poor.

Governments at all levels have not used their powers of financing to deliver adequate personal care to the poor, often surrendering to the power of the professions. The provisions of the Medicare legislation that utilize fee-for-service mechanisms will not appreciably help the poor, since the poor have never been able to use the fees in the way other classes have to secure what they need. Private practitioners are abandoning deprived areas, and, in cities fee-for-service practice is not seen as a solution.[23]

The only force that can really effectively remedy the problem is the poor themselves, acquiring power and seeking a better share of health services. Different segments of society have done that in the past. Trade unions have certainly sought representation on the boards of the voluntary insurance plans that serve their members. Insurance coverage for illness was among their earliest demands.

The exact mechanism for involving the poor has not been worked out, but the value of it is clear. The poor, involved in planning and operating their own services, might offset the self-interest of the professions and the often niggardly financing of local government.

The community action programs of the Office of Economic Opportunity offer the possibility of organizing that latent power. Community organization and community development programs, the idea of the neighborhood service center, techniques using economic and political pressure, and techniques that change the rules of the game, such as the nonviolence movement—all represent new technologies for generating social power, and all have their relevance to securing the broadly

defined health needs of socially isolated individuals, families and groups.[24] Health services is one of the few areas to which the very poor can relate in terms of social protest,[25] and demands for health services might serve as the prime issue around which poor people might be organized.

As a consultant to the Office of Economic Opportunity, the author has been struck many times by the clear sense of the elected representatives of the poor. In one rural southern area, with the health committee of the local Community Action Program, one of the poor insisted that the health officer and the obstetrician on the committee look up the prenatal mortality for the county. It happened to be over 50, possibly related to the fact that babies of the poor are delivered by a "granny-midwife" and are not seen by physicians at any time in infancy. The poor were very aware of the problem. The professionals had blocked it out because their own need to rationalize their lack of concern and to honor their gentlemen's agreement with other professions.

In Detroit, the poor have protested the equipment donated for their care. In Washington, D. C., the poor protested the use of a basement. In both instances their protests seemed to be quite valid for scientific reasons.

The essential outlines of the Gouverneur program in New York City, the pilot project for reorganizing the New York City services, were drafted by a neighborhood group in 1960, and the neighborhood organizations have consistently used their political power to see that their plan was carried out.

The University of Southern California, in its program for Watts, is proposing a neighborhood committee to participate in decisions on promotions, salary increases and tenure for the staff in the Watts project.

In large urban areas, the demonstration programs being funded by the Office of Economic Opportunity may be the model that the organized poor will seek to have replicated in other deprived areas. The programs being developed for Appalachia might serve a similar function.

The poor may find unexpected allies in their efforts. In one rural area, physicians were working with the Community Action Program because they felt that when the poor started to vote they would insist on getting medical care, and they felt that, as physicians, they could not refuse, but would probably have to serve without payment. To what extent the poor could find allies among younger physicians is unclear. However, indications are that medical students are sharing in

the social protest activities of their generation. In Detroit, the house staff at the city hospital struck for better patient services. Unreasonable demands are often placed on these young physicians, who must in many cases treat the poor under inadequate conditions and without social utilities. At times this leads to hostility on the part of house staffs toward the poor, but the frustration of the young physicians might well well be channeled into constructive social protest.

If care is to be distributed to the poor, it will be necessary for them to be organized in Community Action Programs, and they may well find it necessary to borrow some tactics from the civil rights movement in making their demands. In the South and other areas where the poor are substantially barred from care, even without new personnel, better solutions can be found to their problems. Though physicians are not in sufficient number, the midwives and nurses providing care might be trained, given the use of hospital facilities and a physician backup, for example. In fact, such a step might be a ready-made experiment in using personnel in many ways.

In the northern urban areas, the poor should be taught to complain. In New York City, for example, local government is very responsive to citizens' complaints. The poor do not know about or use that opportunity. Finally, however, it may be necessary to picket and demonstrate. In any event, nothing can be done without increased local financing and, in many instances, an attempt to ration professional personnel on the basis of need.

Finally, it is hard to avoid the fact that community action programs may also be a focus for approaching the mental health needs of the poor. Certainly anyone who has watched a group of the poor organized from a defeated apathetic group to an aggressive body demanding their rights, cannot help but support a relevance to mental health. A mental health movement is more than services to the ill. For example, Mrs. C. has been a patient at Gouverneur for three years. A welfare recipient, she was obese, untidy and depressed. She attempted suicide when her daughter became pregnant at age 15, as she herself had. The clinic carried her through that depression, first by daily visits, then by her acting as a volunteer. On the day this paper was written, she was in the clinic organizing welfare recipients, as chairman of the neighborhood committee. She was poised, tidy and talked proudly of her meeting with the Welfare Commissioner.

The benefits of an *entente cordiale* between the medical profession and the community have been summarized by Sheps:[26]

> I believe that one of the mistakes we make in our various professional fields is to feel that we can only make progress by convincing our colleagues through the logic and passion of our approach, that they ought to change. . . . I feel rather that we must look to our allies in the community, because if we examine the history of medicine in terms of organized forms of service, we find that the medical profession reaches to what the community expects. And it is to developing a higher level of community expectation with regard to broad problems and with regard to the best use of resources and programs and institutions that effort must be directed.
>
> The deliberate raising of the level of technological sophistication and understanding of the problem-raising of public expectations—I think will give us the kind of possibility for action which seems most important.

A demonstration program in a deprived community will find the organized poor a useful ally. Specifically, it will help secure necessary local financing, and be a force to counteract the professional self-interest of the medical center with which the program is affiliated.

Since the meeting of the Office of Economic Opportunity mentioned above, a great deal of progress has been made, both in improving present systems of delivery of health care and in testing new modes of delivery. Awareness of the problems has increased, and the problems are gradually becoming more clearly defined. But that is only the beginning of what may be a long road. An almost infinite number of steps are still to be taken. Perhaps the most important of them in the days immediately ahead for local, state and federal governments is to insure social accountability through the mechanisms of such programs as Comprehensive Health Planning and the Regional Medical Programs.

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