SOME ACCOMPLISHMENTS AND FINDINGS OF NEIGHBORHOOD HEALTH CENTERS

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The development of neighborhood health centers in low-income communities throughout the United States in recent years has attracted widespread attention and response. An increasing number of community groups and health institutions have begun to plan and initiate similar activities. Scholars and students of medical care programs have started to devote considerable attention to analyses of the progress and problems of the movement.[1]

Substantial federal financial assistance has been provided since 1966 for planning, organizing and supporting new ambulatory care programs in low-income communities.[2] Grant support was originally provided on a "research and demonstration" basis from the Community Action Program of the Office of Economic Opportunity (OEO) and has expanded to a large-scale nationwide effort aided by both the Office of Health Affairs of OEO and the Health Services and Mental Health Administration of the Department of Health, Education and Welfare (HEW). This paper seeks to review and discuss some of the major accomplishments and findings of these developments from the vantage point of a participant and observer at the national level.

GOALS AND GUIDELINES

The goals and aspirations of the organizers of the OEO "Healthrights" program were both high and broad. Their con-

cerns encompassed improvements in access to services, reform in health care delivery, extension of community participation, utilization of new types of health workers, relationships between health care delivery and other forms of community action and economic and social development, medical care quality and financing, transportation and outreach and a host of related problems.[3] The comprehensiveness of the approach was a function of the complexities of the problems being engaged. Their objectives have been characterized as the "positive pursuit of health"—for the individual, family, neighborhood and community.

Each of the goals involved profound difficulties and obstacles to effective action and change. Efforts to deal with so many factors at the same time were destined to encounter much frustration and failure. A later leader pointed out, "It has been suggested that the neighborhood health center tries to do too much. This criticism may well be appropriate. But in view of the long history of neglect, dare we try less?"[4]

The initiation of the "War on Poverty" in 1964 and 1965 provided a climate and stimulation for innovation.[5] These conditions encouraged a relatively few to undertake tasks that had disheartened many. Their experience seems to support the observations of an analyst of economic development projects overseas:[6]

> If project planners had known in advance all the difficulties and troubles that were lying in store . . . they probably would never have touched it. . . . Since we necessarily underestimate our creativity, it is desirable that we underestimate to a similar extent the difficulties of the tasks we face so as to be tricked by these two offsetting underestimates into undertaking tasks that we can, but otherwise, would not have tackled. It (the hiding hand) takes up problems *it thinks* it can solve, finds they are really more difficult than expected but then, being stuck with them, attacks willy-nilly the unsuspected difficulties—and sometimes even succeeds.

The challenge inspired the imagination and energies of many local groups as well as numerous health professionals and polit-

ical leaders. Strong feelings focused on the need for greater attention to the serious health problems and related unmet needs in poverty areas.[7] Because the breadth of the attack appeared potentially responsive to the dimensions of the needs, the initiative appeared serious and realistic. High risks, though, were inherent in the mission.

The Congressional mandate in November, 1966 for the OEO Comprehensive Health Services Program set the purpose with comparable scope:[8]

> . . . to assure that (health) services are made readily accessible to residents of such areas (of concentrated poverty), are furnished in a manner most responsive to their needs and with their participation, and whenever possible are combined with . . . arrangements for providing employment, education, social or other assistance needed by the families and individuals served. . .

The statutory provisions received operational interpretation in the OEO "Program Guidelines" in February, 1967.[9] The document sought to set procedures toward the broad concepts and purposes. In practice, the formal provisions were to be viewed as too rigid by some and too ambiguous by others.

An HEW program analysis issued in December, 1967 identified comprehensive health centers to serve the outpatient health care needs of low-income areas, along with proposed changes in outpatient clinics and health manpower and financing programs, as principle means to improve the delivery of health services to the poor. The report pointed out that up to 1,000 such centers or similar projects might be needed.[10] A statement by the Surgeon General of the Public Health Service about the same time committed the resources of that agency to work toward similar objectives.[11]

The principle thrusts of the program were summarized in an OEO staff report:[12]

1. How can consumers and providers of health care work together most effectively in planning and carrying out health services?

2. Can the delivery of health care be organized on a team basis to provide high-quality comprehensive personal health care to poor families in a dignified efficient manner?
3. What kinds of new jobs and new careers can be developed in the health care field for poor persons?
4. What are the best ways of relating these projects to other health and poverty efforts?"

Each of the aided projects was expected to engage these issues in its own way.

The aspirations set for the program in its early days resulted in certain misunderstandings in future years. Many viewed them as promises. A few saw them as requirements. Both such views produced disappointment and criticism. As for other OEO programs, cynicism sometimes became the product of expectations that were too simplistic and optimistic.

The tests of accessibility, availability and acceptability set forth in the Program Guidelines, however, have become commonly applied standards for community health services. The bold rhetoric of the 1960's is the common talk of the 1970's.

RESOURCE DEVELOPMENT

Between 1965 and 1971, about 100 neighborhood health centers and other comprehensive health services projects were initiated with OEO grant assistance. About 50 additional projects were started with HEW aid. In excess of $400 million was invested in these endeavors (Table 1). When fully operational, these resources may serve up to three million persons.

Approximately 60 additional comprehensive health care projects for preschool and school age children living in areas with concentrations of low-income families (Children and Youth Projects) were developed during the same period with HEW financial aid. An amendment to Title V of the Social Security Act in 1965 initiated this program.[13] Over $200 million of federal grant funds have been awarded to assist these efforts (Table 2).

The new projects are broadly dispersed geographically. They

TABLE I. AMOUNTS OF OEO AND HEW GRANTS FOR NEIGHBORHOOD HEALTH CENTERS AND OTHER LOCAL PROJECTS

Fiscal Year	*Total**	*OEO Grants**	*HEW Grants**
1965	$ 2.0	$ 2.0	$ —
1966	7.8	7.8	—
1967	50.6	50.6	—
1968	39.5	32.8	6.7
1969	64.9	51.1	13.8
1970	98.5	72.3	26.2
1971	155.4	91.6	63.8
Total	$418.7	$308.2	$110.5

* In millions of dollars.

TABLE 2. HEW GRANTS FOR LOCAL PROJECTS TO DEVELOP COMPREHENSIVE HEALTH CARE OF PRESCHOOL AND SCHOOL AGE CHILDREN

Fiscal Year	*Amount**
1966	$ 13.5
1967	31.7
1968	36.8
1969	39.0
1970	38.8
1971	43.8
Total	$203.6

* In millions of dollars.

are located in about 120 different communities in 42 states; about three-fourths are in urban areas and one-fourth in rural communities. Locations range from northern Maine to the southern border of California to the western coast of Alaska (see Appendix A).

This undertaking has been the most extensive concerted public effort in the history of the United States to expand ambulatory health care resources in poverty communities on a nationwide basis. It has built upon and greatly expanded somewhat similar earlier efforts, both in this country and abroad, to make primary health care services more accessible to poor families in organized settings.[14,15] A substantial beginning has been made in overcoming the serious deficiencies that exist

with respect to health care services in the nation's low-income communities. Legislative actions in recent years encouraging increased expenditures in poverty by other federal health programs suggest an even broader impact has been made; changes in the "Hill-Burton" health facilities program and the community mental health center program (including more liberal matching provisions, up to 90 per cent and initiation of the National Health Services Corps are examples of such actions.

The scarcity of physical facilities to house high quality health services in poverty areas has been a most serious obstacle to the organization of new programs. Through an extraordinary arrangement involving the cooperation of four federal agencies (OEO, HEW, the Department of Housing and Urban Development, and the Office of Management and Budget) and private mortgage and insurance companies, funds have been made available through FHA-guaranteed loans to build new centers in Chicago, Kansas City, Nashville, Philadelphia, Pittsburgh, Rochester and San Francisco; similar negotiations are underway in other cities. These facilities involved long-term investments of $1.5–2.5 million each. Technical guidelines for planning ambulatory care facilities of these types have been an important by-product.[16] HEW and OEO grant funds have also been used for modular units and trailers and to renovate existing buildings, including former warehouses, stores, apartments and convents.

Although the majority of projects involves the development of new "free-standing" health care centers, support has also been given to the other approaches toward the development of comprehensive ambulatory health care services in low-income areas. Hospital outpatient departments have been restructured, poor families have been enrolled in existing prepaid group practices and new medical groups have been established. More ambitious efforts to organize community health networks to coordinate and extend health delivery systems in urban poverty neighborhoods were begun in 1970, by OEO.[17] Table 3 indicates

TABLE 3. PROJECTS RECEIVING OEO GRANT SUPPORT*

Type of Project	*Operational Grants*	*Planning Grants*
Neighborhood health center	19	
Rural services	15	3
Outpatient department	10	5
Group practice	5	1
Community health network	6	6
Total	55	15

* December 31, 1971. Excludes 16 projects transferred to HEW in fiscal year 1971 and 9 projects transferred in fiscal year 1972 (17 of these are N.H.C.-type projects).

TABLE 4. ADMINISTERING AGENCIES OF OPERATIONAL PROJECTS RECEIVING OEO AND HEW FINANCIAL ASSISTANCE, 1965–1971

Type of Administering Agency	*OEO-Aided**		*HEW-Aided*			
			*Comprehensive***		*Children & Youth*	
	No.	*%*	*No.*	*%*	*No.*	*%*
New health corporation	30	37	11	35		
Hospital	16	19	7	22	25	37
Medical school	14	17	3	10	22	32
Health department	7	9	4	13	21	31
Group practice	7	9	3	10		
Other	7	9	3	10		
Total	81	100	31	100	68	100

* Excludes 15 planning projects.
** Excludes 2 projects also receiving OEO aid and 25 projects transferred from OEO. Also excludes 19 developmental projects.

the diversity of approaches receiving aid from OEO as of December, 1971.

Attempts to restructure hospital outpatient departments to provide comprehensive family health services have often been found to be the most difficult. Experiments have been started in both large cities (such as Newark, Boston, Cincinnati, Houston and Los Angeles) as well as in smaller cities (such as Dayton, Oklahoma City and Winston-Salem). As might be expected, changes that involve altering long-established institutional relationships and services usually encounter formidable obstacles.

A wide variety of health care agencies has joined in these projects. Community and teaching hospitals, medical schools, health departments and group practices have been willing to assume new or broader responsibilities along these lines (Table 4). Over half of the nation's medical schools have been involved, in one way or another. As a result, a broad base of exposure and experience has been established. Many factors appear to have motivated health agencies to undertake these assignments; further study of the specific situations will add to understanding of the forces inducing institutional change in medicine and in the society as a whole during the 1960's and 1970's.

COMMUNITY PARTICIPATION

The principle that consumers should participate actively in the development of policies for the centers was a key feature of the original idea and Program Guidelines and has been a major part of the evolving experience. The implications of this requirement were not fully understood by the early planners of OEO.[18] However, the feelings of discrimination and frustration generally present in poverty areas and the lack of responsiveness and sensitivity in health and other community services usually available to them made it urgent to seek substantial changes in methods of doing business. The statutory authorization for the OEO Comprehensive Health Services Program simply stated that services should be designed "in a manner most responsive to their (neighborhood residents) needs and with their participation."

The original OEO Guidelines provided that this goal might be achieved through participation either on an advisory council or a governing board. At least one-half of the former or one-third of the latter were to be neighborhood residents served by the project. The early and active involvement of other community groups, including health professional associations and official agencies, was also defined as an essential feature.

The participation of consumers in planning health service

programs did not seem a radical innovation. Citizen participation on hospital boards and community councils was longstanding. The "Partnership for Health" legislation enacted about the same time required a major consumer role in health planning. The original OEO Program Guidelines drew an analogy to hospital boards of trustees.

Some health professionals recognized that consumer interests could become effective allies in achieving desired changes. An early leader pointed out:[19]

> 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 assumption that low-income consumers should participate actively and equally in policy consideration and formulation was a new emphasis, however. This approach called for new attitudes and behavior on the part of not only consumers but also health professionals and program managers. Such changes were not likely to be easily achieved.

The initial projects were generally organized through the efforts of professional staffs of health agencies who were primarily interested in making changes in the methods of delivering health services. The active participation of consumers has increased steadily, often requiring modification in the organization of the health center. As consumers, health professionals and program administrators have assumed new roles with regard to policy formulation and decision-making, many new practices and relationships have had to be learned and tested. Usually adjustments and readjustments have been necessary to find the system and balance that work best in the local situation.

Through participation on advisory and governing boards, consumers have played a major role in the development of almost all centers. In some cases they were the energizing force leading to the planning and development of the program. In most cases, they have affected the character and concerns of the project in important ways. Their specific activities have most often related to the selection of key staff, service priorities, hours of service, budgets, recruitment of outreach workers and other local personnel and grievances.[20]

The uncertainties and tensions that have often occurred in connection with community participation in health centers have been well reported.[21] Initial analyses of these processes from political and sociological points of view have been published.[22,23] These relationships are likely to be the subject of numerous papers for years to come, thus enriching the discussion of a topic that has received relatively little attention in medical care and public health administration.

Experiences with community participation have indicated the importance of adequate orientation and training if the new roles and authorities are to be handled effectively. HEW grant funds and OEO contract funds were made available for the support of related educational programs early in the development of the health center program. In recent years substantially increased resources have been devoted to such training efforts, especially to prepare boards to handle the duties and obligations that are undertaken in becoming an administering agency and federal grantee.

The experiences of the councils and boards need to be considered in perspective. Many health centers have found themselves involved in basic issues long associated with democratic government. Questions of representation have been essentially the same as those with which western democracy and political science have struggled since the Greek state; it has never been easy to determine who appropriately and legitimately represents others. Voting tallies have often been disappointingly low; as organizers of many other community programs have learned, it

is exceedingly difficult to obtain high levels of voter participation in most nonpartisan elections in the United States.[24] It has not been found that these issues are altered substantially when poor people are involved.

Similarly, disagreements between governing boards and program administrators as to appropriate divisions of power and activities have been similar to those often experienced in many other bureaucratic enterprises. In view of the strong interest in jobs, problems of patronage have been encountered; policies on "conflict of interest" have set standards higher than those often applied elsewhere. Internal struggles for influence have been reminiscent of those common in other enterprises where change is occurring that may significantly affect the future well-being and fortune of the participants.

The health center activities with councils and boards have often been more visible and better reported than similar events in other settings. Higher expectations for involvement and effectiveness have frequently been applied than is generally achieved in corporate affairs.[25] Critics have frequently not been as tolerant of error in these cases as in more established institutions.[26] Confrontations have sometimes involved considerable intensity of feeling and differences in styles.[27] Health professionals have seldom been previously prepared to deal with these types of interactions, thus they have been required to deal with new conditions, sometimes under quite uncomfortable pressure. As in other circumstances, the effective resolution of issues has been found to depend largely upon the quality of leadership and the degree of understanding and skills of those present.

Consumer "demands" for health services in neighborhood health centers have been generally in line with comparable expressions among other consumer groups. Usually interest has focused on needs and desires for more comprehensive services. Increased dental care and drug abuse control services, additional hours of service and better arrangements for transportation and child care have been frequent interests. The desires for broader benefits are notably similar to those reported from consumers

involved in prepaid group practices.[28] They also appear consistent with the tendency of purchasers of private health insurance to prefer more comprehensive benefits. The common concerns of consumer representatives about the sensitivity and attitudes of physicians and other health care providers attest to the continuing importance assigned to personal care and the doctor-patient relationship.

Experiences in the extension of community participation in the development of health centers bring to mind the observation of Winston Churchill that democracy is the most awkward, the most complex, the most irritating, the clumsiest and the best system yet devised in the mind of man. These developments appear consistent with the Jeffersonian faith that when free citizens have adequate information and opportunity they will act in responsible ways. The incorporation of additional groups within the society's decision-making system can be an important stabilizing action.

The health center program has tended to place increasing control and responsibility in consumers. At noted above, the earlier grants tended to be made to health care institutions who helped organize consumer advisory boards. In recent years much greater emphasis has been given to the support of new neighborhood health corporations that include both consumers and providers on the governing board of directors (Table 5). In this matter too, bold aspirations have become common standards in less than a decade.

HEALTH CARE DELIVERY

Health centers have sought to organize and provide comprehensive ambulatory health care to individuals and families.[29] Even though this goal has been difficult to achieve, or even to define precisely, it has indicated the scope of concern and ambition of the planners. Primary care practitioners have been general practitioners in some cases, and pediatricians and internists in others. Increasing reliance is being placed on nurse prac-

TABLE 5. ADMINISTERING AGENCIES OF PROJECTS AIDED BY OEO AT TIME OF INITIAL GRANT AWARD*

Administering Agency	*1965–6* %	*1967* %	*1968* %	*1969* %	*1970* %	*1971* %
New health corp.		24	33	33	52	59
Hospital	50	21	22	67	9	10
Medical school	37	18	11		18	7
Health department	13	18	11			
Group practice		7			9	3
Other		10	22		13	21

* In some cases the administering agency of a project has changed during the life of the project, usually from a medical school to a new health corporation.

titioners and other "physician expanders." The centers have a wide range of medical specialists available, either on staff or through consultation. Dental care has generally received substantial attention. Home care services are being increasingly implemented. Counseling and other supporting social services are usually strong. The weakest area is commonly mental health services.

The efforts to develop comprehensive health services at the neighborhood health centers and Children and Youth Projects reflect not only consumer needs and wants but also the broadening professional interest in organizing such programs.[30–34] Trends in medical education and health services delivery have, in turn, been reinforced by these activities. The interactions of these community and professional movements appear to deserve more extensive analyses.

Health care delivery systems in neighborhood health centers usually have employed health care teams. Various patterns of "team care" have been implemented.[35] This focus arises primarily out of the nature of the health and associated problems identified in many poor families; no single discipline or specialty is capable of dealing alone with the complexities of the conditions present. Teams have often encountered the well-known difficulties of altering patterns of behavior and developing new relations among health care professionals and allied workers. Increased attention to these issues appear to be neces-

sary, through both basic and continuing education, if such methods of health care delivery are to be effective.[36, 37]

The organization of outreach staffs, commonly called "family health workers" or "community health aides," has been the usual approach to improve communications between the center and residents.[38] The record of relatively low utilization of services by poor families enrolled in a prepaid group practice in New York City has pointed up the importance of this function even when income barriers to health care are removed.[39] Other community action programs serving the poor have demonstrated the contribution of "face to face" approaches involving staff members from the community itself in breaking through long-standing obstacles. These workers provide the personal assistance often needed by poor families to deal with conditions that make it difficult, or impossible, for them to use health services and to follow through most appropriately. They have often been trained to provide needed home health services.[40] However, as noted above, the integration of outreach staff into health care teams usually requires considerable preparation and continuing effort.

The comprehensive health services concept calls for much greater attention to prevention and early care. The record of missed opportunities, especially among children, indicated this need was an acute one. Most health centers have made substantial progress in this respect, reporting significant improvements in prenatal and child care, immunizations and dental care. Children and Youth Projects have strongly emphasized initial health assessments and continuous supervision of care. However, in this regard also, experience demonstrates again that established patterns of behavior relating to episodic care, on the part of both consumers and practitioners, are not easily altered.[44]

The unification of health services with related social services is another key aspect. The intimate relation of these issues, especially among "hard core families," demands substantial attention and resources.[46] Similarly, many centers have orga-

nized programs to deal with closely related community and environmental health issues, such as housing and water supply. Many Children and Youth Projects, as well as health centers, have provided a base for organizing day care services.

Patterns of health care among poor families appear to be a good deal more complex and sophisticated than has been generally recognized, involving a variety of providers to meet different needs and conditions.[41–43] Data from "baseline studies" conducted in eight communities where health centers were later developed indicate that about 90 per cent of those interviewed reported a "usual source of care." A clinic was so identified for about a quarter of the cases in a New York City neighborhood and in two-thirds of the responses in Atlanta.[45] As health centers begin services, they "intervene" into the existing patterns; it appears that, in most cases, they do not deal with nonexisting or wholly disorganized arrangements. Further analysis is needed to understand better how poor families incorporate a health center into their previously established health care patterns.

Families usually "register" for care at the health centers. They have generally not been asked to "enroll" and thereby to accept a commitment to use the health center as their sole, or prime, source of health care. This practice can make it most difficult to achieve continuity of care. An OEO-sponsored evaluation study of 21 health centers found that 72 per cent of the user families considered the health center their "usual source of care," with a range of 48 to 91 per cent.[47] However, among those reporting the center as their "usual source," for most centers, 20 to 30 per cent indicated that their last physician visit was to another facility; reports of the last dental visit are similar. Up to 40 per cent stated that they go to another source for the treatment of their most limiting condition. Although these patterns do not appear dissimilar to practice among other health care delivery systems, they dramatize again the difficulties of achieving centrality and continuity of care.[48]

It has been pointed out that consumer "enrollment" in a health plan is only achieved through the actual behavior of the

participants. Many centers are seeking ways of strengthening continuing ties with their registrants and users. The development of such arrangements and commitments will be especially important as health centers seek payment on a prepaid capitation basis.

The development of effective hospital relations has been difficult for many health centers. The problems that some have had in obtaining hospital privileges are somewhat similar to those experienced in the past by physicians in prepaid group practices and by physicians from minority groups. Restrictions of funds that severely limited the dollars available in OEO and HEW grant budgets for inpatient care and that have reduced Medicaid payments for such costs have further complicated this issue. Difficulties of this nature have occurred even in instances when the health center itself is sponsored by a hospital.[49] On the other hand, some centers have systems that insure most effective continuity of care. Strengthening these relations needs the highest priority.

In the past few years special effort has been devoted to the development of projects in rural areas. These projects are focusing on the use of satellite clinics and nurse practitioners and other types of new personnel. One project in Maine is also exploring the use of "interactive television" as a method of long-distance communication and supervision.

Efforts to support the enrollment of poor persons in existing prepaid group practices have been aided by both HEW and OEO. These demonstrations have involved plans in Boston, New Haven, Bellaire (Ohio) and Seattle, a HIP group in Suffolk County (New York) and units of the Kaiser-Permanente Medical Care Program in California and Oregon. These approaches have not only proven feasible but also are producing valuable comparative data on utilization and other factors.

The quality of care at the health centers has been found to compare favorably with other providers. An intensive medical audit program, administered by staff of the Department of Community Health at the Albert Einstein College of Medicine, has

been part of the OEO grant program from almost the beginning and has also been incorporated into the HEW program.[50] This work appears to be the most ambitious continuing activity of its type in the nation. These reports also indicate that more effort is required to achieve "ideal levels" of preventive health care.

A study of the utilization of services at eight health centers has indicated that "registrants" tend to average from four to five physician encounters a year.[51] Even with complete removal of financial barriers and extensive outreach efforts and transportation services, the use of health care services by poor families did not increase to unusual levels (as compared to the average rate of physician services for all persons in the United States.) [52] Utilization tended to be somewhat higher during the first six months after registration, but the rate of patient visits to center physicians even during that period was not excessively high, averaging about five visits per year. These findings appear to have important implications in the consideration of policies for more comprehensive programs of health care financing.

The capability of health centers to reduce needs for costly inpatient care has been documented in a number of cases. A study at the Mile Square Health Center in Chicago indicates the annual rate of inpatient days per 1,000 was reduced from about 1,000 to about 750 over three years. Even lower rates of inpatient care have been reported from projects in Boston[53] and Portland (Oregon).[54]

STAFFING AND MANAGEMENT

The staffing and management of health centers are critical to their survival and success. Uncertainties have existed about the ability of health centers to recruit physicians and other scarce health workers. The exodus of such professionals from poverty neighborhoods has been a nationwide phenomenon.

The health centers sought to develop a number of strengths to help overcome these problems. It was hoped that the adequate funding and modern facilities of the centers would chal-

lenge and make it possible for physicians, especially younger men, to practice modern medicine and social justice at the same time. Salaries were usually set at levels roughly competitive with other institutional settings. Affiliations with medical schools and teaching hospitals, it was felt, might be meaningful and attractive for some practitioners.

Approximately 1,000 physicians are currently practicing at health centers. About 35–40 per cent are full time. The turnover rate appears to be relatively high, with a "half-life" of about two years.[55] It is likely that a large percentage of these physicians would not have practiced at all in low-income areas under other conditions. The percentages of young physicians, black physicians and female physicians working at the centers are higher than the national norms.

A good deal of additional attention needs to be given to issues affecting physician staffing at health centers. Some centers have looked to affiliations with family practice and other residency programs to assist. Ongoing studies of the attitudes of medical students toward health centers, the motivations and the interests of health center practitioners, and the comparable benefits available to physicians in prepaid group practices and other settings should contribute to this key issue. Further programs to increase the number of students in medical and other health professional schools from poverty neighborhoods are also critical.

It has been pointed out that health centers need sufficient autonomy and independence to attract their own types of creative talent, since professional persons attracted to community health endeavors tend to differ in interest and values from physicians oriented toward hospitals and medical schools.[56] The development of linkages and institutional relations that provide desirable support without imposing unacceptable bonds remains one of the most difficult challenges. The neighborhood health centers and community health networks share this dilemma with regional medical programs and other efforts focused on strengthening community health services.

Nurse practitioners and physician assistants have been utilized by a number of health centers to help meet needs. The settings of health centers, the service demand and their relative flexibility and willingness to explore new patterns of care have encouraged such efforts. These experiences have tended to be favorable and considerable expansion in the use of such personnel is likely.[57]

As discussed above, the employment of family health workers and neighborhood residents in other positions has been a key feature. Over half the staff of the centers are residents of poverty neighborhoods; the income received, as well as other aspects of the center, can have a significant economic effect.[58] However, the traditional obstacles to career advancement in the health field have generally frustrated the development of career ladders. Some health centers have established new supervisory levels and have developed broad educational programs as well as liberal policies on educational leave in efforts to alleviate this problem.

The centers have also shared in the shortages and problems of management personnel that characterize the health field. The scarcity of trained administrators, especially for ambulatory care programs, has been compounded by the need for persons with the additional skills required in community-based projects. Both short- and long-term educational efforts have been initiated to help meet this need, involving a number of schools of public health, hospital administration and public administration.

In view of the sponsorship of many of the initial health centers by medical schools and large hospitals, it was anticipated that greatly needed management resources might be made available by these institutions to aid the fledgling centers. With few exceptions, the record in this regard has been disappointing. Other pressures on established health agencies have appeared to be so acute that, in most cases, they have not been able to make available much of the needed talent. In a few cases, help in planning new programs and services has been provided by staffs

of regional medical programs and comprehensive health planning agencies.

As new neighborhood health corporations have assumed increased responsibilities for the operations of the centers, a number have begun to develop contractual arrangements with medical schools for the provision of clinical services. It appears that such approaches may be the soundest method of long-term relations between health centers and medical schools. They serve to define the nature and extent of the commitments that both groups can accept and live with effectively.

Supporters and some critics of OEO have suggested that much of its most important long-term impact may be the result of the opportunities provided leaders from black, Spanish-speaking and other minority groups to assume managerial responsibilities in operating large-scale programs.[59] The health centers have provided many positions for top and middle management personnel in planning and directing local projects with annual budgets usually ranging between $2–8 million. The medical and program managers obtaining experiences in these projects are likely to fill many key positions in the health industry in the future. Similarly, members of governing boards and advisory councils are developing expertise that will be of great value in other settings. Members of these groups are likely to be increasingly active in health planning and other health activities. The acquired knowledge, skills and self-confidence can also have application and impact in other social and economic endeavors.

The National Association of Neighborhood Health Centers may have a significant impact on future health programming. The new national organization of consumers and staffs of health centers provides a forum for the consideration of proposals affecting the future of the health centers, including plans for universal health insurance and health maintenance organizations.

FINANCING

The initial OEO grant support of health centers assumed that long-term financial support would come largely from Medicaid, Medicare and other financing sources. The organization of the centers, in turn, would make it possible to achieve better use of the increased funds available for health services.[60] These assumptions appeared reasonable in the mid-1960's; new large-scale federal health financing programs had been enacted about the same time as the first grants were awarded to health centers. The Medicaid program anticipated the development and support of comprehensive health services for the poor in all states by 1975. To help achieve this goal an agreement of mutual support was signed by the Director of OEO and the Secretary of HEW in May 1967.[61] It was estimated that funds from Medicaid and Medicare might finance 70–80 per cent of health center costs.

The nature of the growth of the Medicaid programs has frustrated the achievement of this goal. State programs have been restrictive with respect to both beneficiary eligibility and supported services. Benefits have been reduced rather than expanded. Some state administrators have resisted the completion of procedures to reimburse health centers. Even the most successful efforts by health centers to obtain Medicaid, Medicare and other private third-party funds has resulted in reimbursements for only 50 per cent or so of their budgets; in most cases, such payments have been in the range of 10–20 per cent.

Amendments to the Medicaid program being considered by the Congress in 1972 included provisions to provide more liberal federal matching (up to 95 per cent) for payments to community health centers and health maintenance organizations.[62] Such legislation will be an important indication of federal policy on the relation between financing and delivery systems and on the encouragement of comprehensive ambulatory care programs. The responses of state welfare agencies to these changes will be important. A number of states, such as Pennsylvania, Utah, Massachusetts, Maryland and California, have agreed to

pay on a capitation basis for Medicaid clients enrolled in certain projects.

Difficulties have also been experienced by health centers in obtaining payments under Medicare. Different policies have been applied to centers administered by hospitals and by "physician-directed clinics." Intermediaries and carriers have usually been unfamiliar with the new systems and issues presented by health centers. Both Medicare and Medicaid have tended to treat hospital-sponsored projects more liberally.

The experiences of recent years have served to highlight and clarify the difficulties of modifying established reimbursement patterns—including those of private, state and federal agencies —to deal with a seemingly new type of provider. Sound long-term financing arrangements for the centers, and other health care programs for the poor, depend upon major changes in national health financing programs. Modification of the strictures of financing programs will also be needed to insure that they do not rigidify existing practices and they facilitate or, at least support, desirable changes in methods of delivering services.

Local planners attempting to develop health centers and similar projects have often been compelled to deal with a multiplicity of federal agencies and grant programs in seeking to mobilize necessary support. The difficulties of working through the present maze in the development of projects in Louisville and Baltimore have been vividly described.[63,64] The conditions confronted in seeking funds from the federal government have often seemed strikingly similar to those encountered by a poor family seeking care in fragmented local health systems.

Comparisons of costs of services at neighborhood health centers has involved some confusion and misunderstanding. A report of a committee of the American Academy of Pediatrics has pointed out: "a problem in comparing costs to families receiving comprehensive care with costs to those using outpatient, well-baby and emergency clinics is that the content of care as well as its costs changes. For example, while hospitalization, laboratory studies and visits to illness, along with their

costs, are reduced, visits for health supervision, time spent with the social worker and the home visits with their attendant costs are increased. The care delivered is no longer the same.[65]

An OEO-sponsored cost accounting study reported that the costs of providing clinical care in health centers compares favorably with comparable services in prepaid group practices.[66] Similar findings have been made for children and youth projects.[67] In light of the general similarity of the elements of costs, and the projects' efforts to emphasize ambulatory care and reduce inpatient days, this finding is not surprising. On-going work in the centers to implement more refined cost-finding methodologies will produce substantially increased data on the costs of ambulatory care services, including build-up costs.[68]

As noted above, the health centers provide a variety of health and related services. Many of these benefits have not been included in traditional insurance "benefit packages." Uncovered services may include dental care, mental health and home health services, drugs and glasses, as well as transportation, outreach, child care and other supporting services. The work of the centers will provide further information on the costs and feasibility of financing more comprehensive benefits of this nature. They also highlight the critical importance of interrelating both delivery and financing mechanisms for medical and social services to meet the full range of health and health-related needs.

The annual per capita costs attributable to outreach, transportation and such special items as in-service education appear to be less than the costs of a half day of inpatient care. If health centers can achieve significant savings in the use of inpatient care they will be in a strong position to finance such services on a long-term basis.

The development of partial and full-pay private payment plans for neighborhood health centers has become of critical importance. It had been assumed, at the beginning of the OEO program, that 80 per cent or more of the families living in areas of "concentrated poverty" (where centers were being orga-

nized) were below the "poverty index." Thus it was planned that services would be made available on the basis of residence alone. It was expected that almost everyone in the neighborhood would be eligible for comprehensive care financed by the Medicaid program. In practice, however, it has been found that families below the poverty index tend to account for only 40–60 per cent of the population of low-income neighborhoods.

A Congressional amendment to the OEO Act in 1967 limited free care to "low-income" residents; the OEO policy called for the use of the poverty index or the appropriate state Medicaid income standard to make such determinations and emphasized that it must be applied in ways that were not obstacles to needed health care or infringements of personal dignity. Experience demonstrated it was unrealistic to attempt to provide a full range of health services without charge to a large number of families who were not considered "poor." On the other hand, it was equally unrealistic to expect families with annual incomes just above the poverty index to pay the full costs of services. Thus, the development of acceptable partial- and full-payment plans became crucial.

Congressional interpretations of the amended provisions of the OEO Act in 1969 made it possible to provide that up to 20 per cent of the families registered at an OEO-aided center might be served on a partial- or full-pay basis. OEO policies provided that partial-pay plans might include families with incomes up to twice the poverty index—$7,600 per year for a family of four in 1971—with progressive increases in charges. Because HEW grants were not constrained by such statutory provisions, more flexible approaches to this issue were possible. Both OEO and HEW encouraged payment arrangements on a prepaid capitation basis and such plans are being planned and tested at some centers, e.g., Salt Lake City and Louisville.

An amendment to the OEO Act was approved by the Congress in the summer of 1972, and authorized a further liberalization of the policy of that Agency so that grant funds might be used to help centers serve all residents of the low-income

neighborhood, either without charge or on a partial- or full-pay basis. To meet the genuine concern of some that "creaming" may occur, as has happened with respect to other public services, it has been proposed that the percentage of registered families below the poverty index be at least equal to the proportion of the poorest families living in the neighborhood.

The development and use of partial and full-pay private payment plans are essential under present circumstances so that the centers may achieve the goal of becoming neighborhood institutions. Otherwise, they can become divisive forces within the community, marked with derogatory labels. Further, it appears that the health conditions and practices of neighborhood residents tend to be quite similar, regardless of income.[69]

The tortuous history of OEO policies in this regard has been part of the indecision regarding the extent of federal aid to be made available to the "near poor" and the "working poor." Similar issues have been debated in recent years with respect to such other programs as Head Start, Legal Services, Day Care, and Welfare Reform.

It has become widely recognized, however, that public action to develop needed quality health resources and services in low-income neighborhoods must be done in ways that do not perpetuate systems of services for the poor, a condition no longer acceptable to either health professionals or the poor themselves. Additional health care resources are required to serve not the poor alone but all who live in low-income communities.

GROWING TALLER

Much has been accomplished in five years, but even more remains to be done. No one is likely to suggest that answers have been found to all the major needs and concerns that inspired the effort. Probably the greatest gains have been to increase understanding of the nature and dimensions of the questions. In view of the widespread interest in the health centers their further gains and shortfalls are likely to be well re-

ported and analyzed. One aspect of their development, though, has been perhaps best covered by a speaker at the recent dedication of a center in a rural community in a southern state.[70] The speaker described the project as "a credit to the community" and indicated, "you can't tell us that it isn't going to succeed because we know it is. We're going to make it succeed. We're going to be taller," the speaker concluded, "because we are somebody and we're not afraid."