Primary health care and the poor in the inner cities of New York and Washington, U.S.A.*

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In the hurry-skurry of money-making, men-making and machine-making, we have altogether outgrown, not the spirit, but the organisation of our institutions.

Disraeli

Medico-social problems

As the inner cities of the larger American towns decay, the rich tend to move to dormitory suburbs: both New York and Washington D.C. are typical. The poor who remain are predominantly black, and are crowded into drab areas along with ageing white residents who cannot afford to move. This flight of the middle class leads to an erosion of the city tax base and a loss of the better educated leaders of the community. The ensuing lack of funds and the difficulty of the poor in articulating their demands leads to a rapid decline in the quality of social services.

The District of Columbia is the nation's capital and forms the core of the town of Washington. Its glorious situation, its fine buildings, including the White House and the Capitol should all make it a delight to live in, and yet its white population declined by 40 per cent in the ten years to 1970 and the black residents increased to 70 per cent of the 750,000 population.

The overall infant mortality rate is 31 per 1,000 live births (in the United Kingdom it is 18·6: in Jamaica, 34·7.) A closer look at two different public health areas in the District reveals the great disparity in health status between the poor and socially deprived blacks, and a remaining middle-class area.

TABLE I

WASHINGTON D.C. STATISTICS 1967–8

	Service area number	
	6	8
Population	79,000	99,500
Percentage of blacks	*92*	*3*
Infant mortality (1)	40·3	12·4
T.B. rates/100,000 (2)	116·6	14·0
V.D. rates/100,000 (3)	3047	168

(1) Figures for two years
(2) New active cases
(3) Newly reported cases

*From a report of a Nuffield travelling fellowship.

New York statistics also show the inferior health of the blacks (native born American negroes), who are virtually synonymous with the poor. In that city there are probably over two million Puerto Ricans (negro, Spanish-speaking West Indians) who form a less socially-disrupted group than the blacks, and they have a better health record. However, the areas where they live have a dearth of social services—one section of Puerto Rican and black residents had only five private doctors for 45,000 residents.

TABLE II

INFANT MORTALITY COMPARISONS. MANHATTAN ISLAND. NEW YORK 1969

	Population	*Percent non-white births*	*Infant mortality rate*
Central Harlem	231,000	*92·8*	42·5
Kips Bay	245,000	*5·8*	16·8
Manhattan Island—total	1,745,000	*34·2*	25·5

The housing situation in the ghetto areas of New York is gloomy, and as tenements decay it is easier for the landlord to vanish than to attempt repairs. The tenements are infested with cockroaches which may fall into the food during cooking, and rats abound —380 rat bites were reported by residents in 1968.

Fire is an ever-present hazard as people attempt to keep warm, and as there are no public lavatories in these areas, drug addicts and others foul the hallways. Old plaster with flaking paint caused 863 cases of lead poisoning in children being reported during 1968 in New York, and undoubtedly there were many more subclinical or unreported cases of this disease which can result in permanent intellectual impairment.

The authorities have housing schemes to replace areas of tenements, and these huge and impersonal blocks perpetuate the one-class nature of the district. Violence and bag-snatching are common, breeding fear which spurs on those who can afford to escape from the area. Shops, including pharmacies, in the ghetto areas tend to charge more than in other parts of town.

The blacks have a higher rate of unemployment than whites, and the jobs offered are frequently menial, Negroes form 12 per cent of the population in the United States of America, but only two per cent of the doctors. This causes much frustration and feeds on the feelings of personal insecurity which arise from historical causes such as slavery with its broken family life, legal discrimination against blacks, and the still-potent racist feelings of the white majority. Many blacks have come to hate themselves with contempt, and the whites with bitterness. This, perhaps, assists explanation of the social and psychological decay which has led to the heroin-addiction epidemic, the incidence of alcoholism (50,000 estimated alcoholics in D.C.), and the high suicide and homicide rates in the ghetto areas.

Officially, there are 100,000 heroin addicts in New York alone; informed opinion suggests this number can be doubled: most families include an addict. In Washington 91 per cent of addicts are black, and in one section of the city it is estimated that 38 per cent of the men of 20–24 years are addicted. The habit costs 30–50 dollars a day, and 45 per cent of all new jail admissions in the District of Columbia were heroin addicts.

Further evidence of the disorganisation of black family life comes from the number of children born out of wedlock, and also the large number of children under 18 referred to juvenile courts.

The health status of a community is shown by its mortality, morbidity and the

amount of disability present. On all counts the poor, who are mostly black in the inner cities, score badly. Overall in America the life expectancy for blacks is 63·6 compared with 70·2 years for whites. These statistics come from American sources. A black leader said "We are sick to death of surveys—we want service, and with dignity."

Health services

To the British observer, primary health care for the poor in the inner cities of the United States of America presents an extraordinary mixture. Within one area every variety of work may be seen, ranging from fragmented impersonal services made indifferent through routine, to exciting new ideas.

This variety is due to the American attitude to democracy with their emphasis on a rugged individualism, on a plurality of approaches and the devolution of responsibility to the periphery. Gradually the Americans are facing up to their own great crisis of inequality and the right of the individual to health care.

The first organisational and financial steps to a fair provision of personal comprehensive health services were taken by the Office of Economic Opportunity (O.E.O.) programme of the Johnson administration, and the Medicaid/Medicare legislation. The former has been a successful demonstration suggesting future developments in health care; and the latter, while placing the poor in the mainstream of medical care for the first time, has provided some costly lessons in medical economics.

However, medical care for the poor remains a tawdry thing in the States. The rapid rise in health costs is making even the middle class medically indigent, which puts pressure on the Government to act. Health care has moved to the centre of the political arena and there will be great changes in the next few years.

Primary care services are available to the poor through the city authorities, the medical schools, the Office of Economic Opportunity programme and the various groupings of private doctors. Every combination of these agencies occurs to form a tangled skein with many holes, through which patients often fall.

Financing health for the poor

One federal definition of poverty has been an income less than three times the cost to feed a family of a given size. This is approximately an income of 3,600 dollars for a family of four in an urban area; but using additional criteria of 'medical indigency' New York at first decided this applied to a family of four with an income below 6,000 dollars after tax. The federal definition of the medically indigent has now been modified to 133 per cent of the income level set for public assistance in any state.

Medicare (for the aged) and Medicaid (for the medically indigent under 65) legislation was introduced in 1966 and forms most of the federal expenditure for health. It covers the blind, the disabled, dependent children, the aged and the medically indigent under 65 years (although it is not incumbent upon the States to include the latter until 1975). Financing is by a formula whereby wealthy States receive 50 per cent federal support, the State pays 25 per cent and the local city 25 per cent.

Benefits include hospitalization, physician's fees, outpatient clinics, nursing homes and laboratory diagnostic services; supplemented by existing services (such as dental and nursing services and free drugs in New York). Payment is by fee for service to the private sector, fee per visit to the outpatient department, and fee per day to hospitals.

Originally 2,500,000 out of the 8,000,000 in New York enrolled, and the rush for services and excessive claims threatened the city with bankruptcy. In 1968 cost reduction was effected by redefining medical indigency as an income below 5,000 dollars for a family of four, and by reducing all private sector fees by 20 per cent. This left 1,700,000 people enrolled in New York.

The scheme has enabled some of the poor to transfer from hospital emergency-room treatment to individual care in the private sector, and has reduced some of the backlog of medical neglect. Some doctors have been enticed into ghetto areas, and there has been the beginning of quality and cost control.

There is a maximum number of patients in a day for whom the doctor will be paid, certain diagnoses must be confirmed by laboratory means, and certain tests must be undertaken outside the doctor's laboratory, in addition there is some check on the use of indiscriminate consultation referrals (medical 'ping-pong').

The disadvantages include over-use by patients who may 'shop around', the system of payment encourages over-use by providers; various administrative loopholes permit excessive claims to be made. Payments may be long delayed.

The greatest expense is hospitalization, and as hospitals are reimbursed on their annual running cost there is no stimulus towards economy of inpatient or outpatient care.

The greatest disadvantage in health terms is that medicaid item of service payment does not encourage the development of continuing responsibility for a patient, with all that this implies in terms of health education, preventive medicine, and guiding the patient into the appropriate part of the medical system.

The Office of Economic Opportunity offers funds for personal comprehensive health and social services in poor areas through neighbourhood health centres which have an arrangement with a local hospital for inpatient care. It provides funds for premises, staffing, equipment and drugs, while patients are expected to pay through Medicaid or Medicare, or make part payment on a sliding scale. Exceptionally the programme will pay for the treatment of certain patients.

Grant applicants are usually part of a community-action programme and must aim to provide dignified personal care with the maximum participation of the poor in policy making. The centre must offer education and employment in reception or other para-medical roles for local residents.

The operating agents are usually a health department, a medical school, a hospital or group practice. The whole operation is both carefully monitored, and innovative as it also has a social research and development role. So far there are about 90 of these lavishly-equipped centres across the United States serving over a million patients. There are seven in New York and four in Washington.

Hospitals

The hospital emergency room is frequently the poor man's doctor in the inner city. The municipal hospitals in New York are affiliated with teaching hospitals in an attempt to upgrade the quality of service; while in Washington there are the D.C. General Hospital and the teaching hospitals of medical schools. Payment at all hospitals is through Medicare, Medicaid or in cash by the patient.

Hospital-based primary care leads to a fragmented, emergency-orientated service. This is characterized by long hours of waiting, a lack of communication with the patient and a lack of continuing responsibility by medical staff. The patient, who is frequently not well educated, attempts to co-ordinate his own care as he lacks a guide through the medical maze.

The hospital doctors, lacking a long-term relation with the patient, often resent their time in the 'minor' side of the emergency rooms, which tend to be staffed by young doctors seconded for a short period, by doctors working for their state licence to practise, such as Filipinos, or by elderly doctors whose careers have been disturbed for various reasons. This multiple medical care arouses feelings of insecurity in the younger doctors, which leads to multiple referrals and over-investigation.

The hospital authorities are aware of these problems which they have attempted to solve in various ways.

Mount Sinai Teaching Hospital

The emergency room is staffed by interns (doctors in the first year after qualification) for a month each, and by residents for five days each two months during a year. They rotate through the medical, surgical and paediatric sections. Patients may present at the emergency room or go directly to the general medical clinic.

In the emergency room one patient had waited 2½ hours and had three more ahead of him in the queue. A woman of 30 seen by an intern, with a small aphthous ulcer of the mouth, had waited two hours for a second opinion by the ear, nose and throat resident. Another woman of 25 with influenza and mild headache required a second opinion by the neurological resident.

The general medical clinic also serves patients direct from the street. It is staffed by interns and part-time doctors, who undertake from one clinic a week to one clinic a month, so there is little continuity, and preventive services are separated from curative work, as the former are not offered by hospitals.

Harlem Municipal Hospital

This new hospital is used by 70 per cent of patients in central Harlem for primary medical care. It has a most lavishly-equipped and staffed emergency room and a walk-in clinic. New patients attend both sections indiscriminately.

A system of triage is increasingly popular in American hospitals, and is designed to conserve the skills of scarce medical staff. This derives from the battlefield, where decisions are made about wounded men—those who need moving to base hospitals for major medical care, those who will die regardless of treatment, and those with minor wounds requiring simple attention available at the front line.

In the emergency room a triage doctor does this work for a month after his year of internship, and refers patients to the surgeon, internist or gynaecologist in the emergency rooms, to the outpatient department, or to the walk-in clinic.

The doctor observed walked over to the main waiting area and called the patients by name to wait in the inner triage waiting area, and was not assisted in this by any reception staff. Patients seen included an asthmatic who required a repeat prescription; a woman with arthritis of the knee, who was x-rayed and referred, without the film being read, to the outpatient department; and a patient with dental haemorrhage who was referred to the dentist.

In the walk-in clinic the patients wait in rows, and queue in a line to see another triage doctor. Some have a note from the emergency room triage doctor, some require repeat prescriptions, and only those who are referred on are sent to have medical records prepared. The patients have their name, address, diagnosis and the name of the triage doctor entered in a ledger.

A patient seen by the doctor in the second part of the walk-in clinic presented with tinnitis to the emergency-room triage doctor, was found to have hypertension, given a work certificate and referred to the walk-in clinic triage doctor. She referred him to the second doctor at the walk-in clinic, who only had the work certificate to go on. This doctor elicited a history of nocturia, examined the chest and blood pressure, ordered some investigations and treatment and then referred the patient on to the medical and the urological clinics!

Such fragmented work methods depersonalizes the doctor-patient relationship and wastes scarce medical resources.

The District of Columbia General Hospital (Washington)

This emergency room is a modern, well laid-out and equipped, extensive department, in which patients are seen in cubicles. It is well administered and has been the subject of recent work studies. The emergencies are seen immediately in the stretcher room, but 85 per cent of patients attend for non-urgent primary care.

The receptionist records the presenting symptom and a nurse takes the vital signs including blood pressure and urine and decides who needs priority. Then the triage doctor sees the patient and either deals with trivia and repeat prescriptions, or refers the patient to the other interns or residents in the emergency room. The average time from registration to discharge by the doctor is 81 minutes, though some patients wait five to six hours.

The triage doctor was observed at work. The first patient was a diabetic who attends the diabetic clinic. She had just been to the gynaecological clinic for a cervical smear and now came to triage for a repeat diabetic prescription. Her old notes had been mislaid and she was seen with only emergency-room records.

The second patient attended the paediatric clinic with her four year-old child at 09.00 hours for his pharyngitis, and had spent the rest of the day at the hospital to be finally seen by the triage doctor for her own upper respiratory tract infection at 15.30—the child was understandably fractious.

The next patient was a 17 year-old male with a rash on the palms and feet. This was thought to be secondary syphilis and so blood tests were ordered and he was referred to the venereal-disease clinic. There was no explanation nor any questioning about his sexual activities. In all this time there were several interruptions by lay and medical staff.

The Bronx-Morrisania Ambulatory Care Unit (New York)

This modern building on five floors is an attempt by the Bronx-Lebanon Hospital and the Morrisania district health centre of the New York health department to integrate primary care. It combines the outpatient department of the former with preventive-medicine services. The premises had been broken into overnight for the fourth time this year and ransacked. Scattered used syringes suggested heroin addicts were the culprits.

The medical comprehensive clinic has nine internists offering curative care, replacing the private doctors lost to the district. They work from 09.00 to 16.00 hours with an hour for lunch and see 20–25 patients a day. Both here and in the paediatric department there is an attempt to give continuity of care although the doctors tend to stay only until they receive a licence to practise privately. The excellent paediatric department has medical-social workers and public-health nurses. Records of defaulters are reviewed and an attempt is made to visit them at home, although many are found to have moved from the neighbourhood.

The local authority services are housed on a separate floor, and perhaps more functional integration could be achieved.

George Washington University Medical Centre (Washington D.C.)

This teaching hospital has an emergency room operating triage and episodic care, and screening and continuing-care clinics in another building.

Screening clinic patients have either been referred from the emergency room or have come direct. This clinic handles walk-in episodic care and may refer patients to the continuing-care clinic. There is a rotation of interns between the emergency room and screening clinic so they can refer patients to themselves for a limited follow up.

The continuing-care clinic is staffed by part-time doctors who spend about 25 per cent of their time in the department.

The division of medicine is responsible for ambulatory care and aims to educate students in the problems and process of health delivery, to offer medical care to a defined community, and to research into subjects including finance and the auditing of the quality of care.

It is planning a Health Maintenance Organisation offering comprehensive health care to a defined population. One doctor stated that the disorganised pluralistic system, the overlap with the local authority and funding problems all make it difficult to get the community health programme going.

The local authority health services

The Department of Health in New York offers primary care services through 22 district health centres, 95 child health stations, and through the emergency rooms of the 18 municipal hospitals which have already been discussed. It suffers from a shortage of doctors and public health nurses, especially in poor areas.

The district health centres offer well-baby clinics, venereal disease, chest and dental services. The child health stations are strategically situated in the city and usually offer preventive care until the children reach six years. However, experiments are being carried out in eight different centres where 50,000 children receive total medical care until 18 years, and these are financed by a variety of agencies.

At a standard child health station children are examined by a doctor at six weeks, three months, nine months, one year, 14 months, 16 months and then half yearly, while the public health nurse would work at two such centres, at one to two schools, and make one or two visits a week. Such work is dull for the doctor and public health nurse, tends to be orientated by middle-class ideas and does not reach out into the community for non-attenders—the vast number of problem families.

Some district nursing for the poor is provided by private agencies who are reimbursed by the local authority, thus local authority, professional workers rarely reach into homes.

The Department of Human Resources in the District of Columbia has seven departments, the first four under the aegis of the Public Health Department:

1. Community health services.
2. Hospital and medical care, which runs the District of Columbia General Hospital (acute), a chronic sick hospital, and administers Medicaid and similar programmes.
3. Narcotic treatment administration.
4. Mental health administration.
5. Social services administration—for the underprivileged.
6. Veteran affairs administration.
7. Vocational rehabilitation—for the handicapped.

The economics of public health in Washington are plagued by funds coming from a variety of sources—for example Congress provides for indigent primary care, while Federal grants offer categorical funds for tuberculosis and venereal-disease programmes. The budget has been diminishing during the past three years.

The residents of the district of Columbia vote for a congressman (who has no vote in the House) and the President, but have no vote in local government. The mayor and the city council are appointed by the President, and as funds are voted by Congress they are subject to political manoeuvring by congressmen who are more interested in votes 'back home' than in good health services in Washington.

The mayor appointed a task force on public health goals which reported in 1970 with a subtitle *The crisis of impotence: towards competence in health for the District of Columbia.* It stated:

"The District of Columbia is health poor, nearly health bankrupt and . . . over the whole city, the quality of available health care for large numbers (the black, the poor, and the uninsured lower middle-class whites) is often inadequate and inhumane. Such services as they are, are so fragmented as to be inaccessible to many or most."

The organisation of community health service is evolving, and formerly only certain categories of care such as child welfare, tuberculosis and venereal diseases were covered. Now there is a move to the creation of neighbourhood health centres offering 'one stop' medical care for the indigent, including the major specialties.

Thirty centres were planned to serve 25,000 patients each, there are nine now, but a shortage of funds has slowed expansion, while similar centres promoted by special interests have started. The Office of Economic Opportunity is sponsoring a centre with a university to include teaching, and the National Medical Association Foundation (an association of black doctors) has its own neighbourhood health centre. Several workers complained that there is little co-ordination or communication with these other centres.

Para-professional workers

Across the United States of America there are experiments in training such workers. Local residents in poor areas receive training to assist in child-health stations, neighbourhood health centres and hospitals. The programmes have two objectives:

1. To provide outreach facilities to non-attenders, and to bridge the gap of non-comprehension between the professionals and their clientele, who (being Cuban or Puerto Rican) often fail to understand through cultural differences, or through an inability to speak English.
2. To provide education, skills, work and growing self confidence for the socially deprived.

Community health workers, warm and responsible women, work in some child-health stations in New York, making home visits and assisting the public health nurses.

The Martin Luther King Junior Health Centre in New York offers a core programme to improve reading and writing skills, to explain opportunities for training and to assess the applicants. Then specialized training is given to create family-health workers and medical assistants (who weigh, take blood pressure, prepare injections and act as translators). In-service training is offered to upgrade their services, and to produce operating room and x-ray technicians. Additionally it has been necessary to offer middle-management training so that inexperienced community residents can eventually rise to supervisory positions.

Health Centres of the Office of Economic Opportunity

Conceived and financed by the Office of Economic Opportunity the operation of these comprehensive care centres for the poor has been inspired by the prepaid group-practice schemes such as Kaiser Permanente and the Health Insurance Plan of New York. They are having a major effect both in the design of total care delivery at present, and in furthering the concept of the health maintenance organisation.

They spring from community action programmes so, for example, the Cardozza Community group health foundation was inspired by a group of five underprivileged mothers who had to travel all over the District of Columbia to get certain categories of health services (child welfare in one place and curative services elsewhere). There are about 100 neighbourhood programmes scattered across the United States of America.

In addition to preventive, curative, social and sometimes legal services, the centres must offer education and employment in para-professional roles for local residents. There is strong participation in policy making by the population served; and the Office of Economic Opportunity has stringent reporting requirements from each centre to ensure

its objectives are being reached, and that it does not degenerate into a hierarchy unresponsive to local needs.

The centres visited all had connections with hospitals to ensure total patient care, with medical schools for teaching, and they undertake research. Regrettably little attempt had been made to meet the few remaining private doctors still working in the poor neighbourhoods, to help them with their problems and to draw them into the mainstream of medical care. Morale was universally high in comparison with other places visited, and doctors were delighted to have returned to a relationship with patients as people.

The neighbourhood centres visited were all lavishly planned, equipped and staffed. The primary care staff was divided into teams, serving families; and a team consisted of an internist, a paediatrician, two public health nurses and four family-health workers in one centre; but also included a dentist, a nutritionist, and a medical-social worker in another centre visited. Consultants from the major specialties held sessions at the centres and doctors were usually able to treat their patients in hospital.

All members of the team worked at the same time in the same unit where possible, to establish close liaison, and 30 minutes were allotted for a new patient, with 15 minutes for follow-up. Patients' records were filed by numbers and sometimes family folders were used.

Problems met as usual included a high infant mortality, bad housing, disorganised families, much alcoholism and drug addiction, and psychiatrically disturbed patients.

In general the aim of providing dignified personal care was fulfilled in the Office of Economic Opportunity centres, and in the crumbling neighbourhoods where they are placed, these programmes offer a beacon of hope.

Private practice

The Health Insurance Plan of New York

The Health Insurance Plan offers prepaid, comprehensive group practice on a capitation basis, in the manner introduced on the West Coast by the Kaiser Permanente Health Plan in the 1930s. Similar groups exist across the United States of America serving altogether about five million patients. The patients are employed persons enrolled through group schemes—such as city employees (police, teachers and firemen), and some trade unions. A free drug scheme can be chosen by the patient. Such a group-orientated plan has many attractions in the delivery of health care, but until recently has excluded the poor.

The Health Insurance Plan is a central body, analogous in some functions to an executive council in Britain, and has semi-autonomous medical groups operating across the city. It provides organisation and administration, a central laboratory which collects specimens twice daily and an emergency service programme for night calls and holidays. It has no hospital beds (unlike the Kaiser scheme) but has arrangements to pay for the hospitalization of its enrolled members. There is a joint board of the groups and the Health Insurance Plan, to develop policy, and various other committees. Approximately 750,000 patients are served. In all Health Insurance Plan centres there is a regular medical audit on the quality and costing of medical care.

The Yorkville group of the Health Insurance Plan has opened an East Harlem branch in a converted building, for patients on Medicaid, and is working closely on the project with the department of community medicine of Mount Sinai medical school. This scheme was made possible by negotiation with the medical assistance section of the New York Department of Health, and the scale of fees paid is based on Health Insurance Plan charges. At first it enrolled 15,000 patients, but with the cut-back in medicaid criteria this fell to 9,000.

The East Harlem non-professional staff are ghetto residents (blacks and Puerto Ricans) and in due course the branch will be housed in a purpose-built centre on a new housing estate. The department of community medicine is conducting experiments and demonstration programmes to ensure that the new centre will offer the most effective structure and functions for local health services.

The centre has full-time doctors (internists and paediatricians) with hospital-admitting privileges, and part-time specialists. New patients register with an individual internist and receive a full examination. A doctor sees about 25 patients in his office each day, visits his one to five patients in hospital daily, and makes perhaps two to three home visits a week. Doctors are paid a salary which is a share of the profits, but if he sees a private, non-enrolled patient, he keeps a proportion of the fee.

The East Harlem branch has a health educator, a nutritionist and a medico-social worker, and offers special programmes for adolescents, for sickle-cell sufferers and against lead poisoning. Another study under way is a comparison by multiphasic screening of the employed and the medicaid patients, in an attempt to see if screening can upgrade health, and this is supported by a federal grant.

The health educator arranges meetings around such problems as sex in adolescence, acne, and heart disease; she provides health handouts and posters, and individual patient counselling for those with heart disease and so forth.

One difficulty the centre faces is that a patient registered with the Health Insurance Plan and possessing a medicaid card can 'shop around' for care, and this breaks the continuity of management. Another problem was the unilateral cutback in Medicaid. This involved the centre in financial loss as they had made capital outlay and employed staff to deal with the original and larger number of patients.

'Medicaid emporia'

Several groups of doctors have opened premises to serve poor patients. They offer x-ray and laboratory investigations in addition to an outpatient type service with no night responsibility. I noted that medicaid item of service payments are readily open to abuse by ordering of excessive investigations and by unnecessary cross-referral within the group. However, the patient does receive a personal service. Furthermore, the doctor in a ghetto area is personally at risk—the doctor visited had been held up at gun point by a heroin addict. This doctor stated that the system distorts the needs of the patients to supply the needs of the doctors.

General practitioners

These are hard to find in ghetto areas and only one was visited. He offered an excellent service (" patients can recognise caring in a volume practice") and knew his patients well. He limited the number of medicaid and medicare patients seen, to avoid a drop in income as he was not prepared to exploit inadequacies in the Act to make money.

Free clinics

The first clinic opened in the Haight-Ashbury area of San Francisco—the centre of 'hippy culture'— in 1967. Since then volunteer young doctors and senior medical students have opened about 200 free clinics in poor neighbourhoods across the United States of America. They represent an action programme of the New Left founded on the conviction that the American medical system fails to meet the peoples' needs, and any restructuring should not be left in the hands of middle-class liberals, who will re-create a new hierachy. They would prefer community or worker control of institutions, with a demystification of medicine.

The services offered at the clinics are enthusiastic, amateur in that they aim to abolish professional boundaries, and they are often ephemeral as the part-time staff moves to new jobs in different areas. However, they provide a field for experiment and

service to support the questioning of these young radicals. Payment may be voluntary, with a box in the waiting room, and equipment may have been scrounged from different sources.

The free clinics are entirely independent, but organisations such as the Medical Committee for Human Rights and the Health Policy Advisory Centre, which publish news about the clinics, act as informal lines of communication. These organisations, through their bulletins and position papers, provide a forum for information and discussion by radicals on all aspects of the planning and delivery of health care.

Medical schools

Most medical schools are private institutions which receive federal grants for research projects. This has enabled great advances to be made, and America has the largest number of Nobel laureates in medicine. However, such a method of payment tended to make teaching an offshoot of research. Until recently, funding has concentrated on biomedical research, rather than health care delivery.

The Government, responding to the country's needs, as does the Carnegie commission report of 1970 on policies for medical and dental education, has now begun to fund schools according to the number of doctors produced, with a bonus for students who qualify in three instead of the usual four years. This is promoting curriculum experiment, as standards are maintained by external criteria. Pressures on medical schools include a move towards adequate representation of minorities, so that the black student intake will rise towards 12 per cent.

Medical schools increasingly recognise their responsibility to the community beyond the hospital walls. Many new departments of community medicine have opened, and departments of social and preventive medicine are more closely examining and involving themselves in systems of health care delivery. Mount Sinai School of Medicine in New York and the Georgetown University medical school in the District of Columbia are typical in that they traditionally provide curative medicine to the poor through emergency room services, and are now planning comprehensive health services for large communities.

There are many reasons, reflecting the greater social awareness of a modern integrated, interdependent and complex society. They include:

1. Recognition that the behavioural sciences offer a contribution to medicine analogous to that of the physical sciences.
2. The next great advance in American medicine lies in the planning and introduction of health care delivery systems.
3. The need for a holistic approach by doctors who are orientated towards the patient as a person in his total environment, as opposed to the production of specialists.
4. An increase in student numbers requiring access to more patients, at a time when Medicaid has led to an exodus of poor patients from the primary health care offered by hospitals.

The department of community medicine at Mount Sinai is very new, with a wide view of its responsibilities. Care has been taken to consult the local community and mutual understanding has developed.

Recognising the many factors impinging on health in a modern society—such as family life, education, housing, work, money and race relations etc.—the department is building two approaches:

1. Specific interventions in the life cycle in a growing series of service experiments:

Stage	*Programme*	*Health risks*
Pregnancy	Antenatal	Maternal and infant
0–5 years	Infant health	Lead poisoning, feeding
School age	(a) School health (b) Educational (c) Adolescent	Teenage pregnancy Addiction
Adult Geriatric	Not planned	Industrial, Cardiovascular

2. Planning and preparing for a new Health Maintenance Organisation in East Harlem, with the Yorkville group of the Health Insurance Plan.

The infant health programme provides total health care at a local authority child-health station, using community health workers (specially trained local residents) to ensure that mothers attend. The public health nurse is the first contact because of the doctor shortage and is being trained to conduct physical examinations (heart, ears, abdomen and developmental screening).

The high school has 85 per cent Puerto Rican and 15 per cent black children, and health is used as a tool in the secondary education of these relatively deprived children. A health care curriculum stimulates reading and writing skills by health education. These activities help raise the self esteem of the children, and encourage them to be responsible and caring people.

Medical treatment of adolescents tends to fall in a gap between the paediatrician and internist in the United States. The young have special problems of personal identity, they are at risk from drugs, and youthful sexual awareness is also a problem. The department has a programme under way to help them.

Medical students spend six weeks in their last year in the department, and produce a written report on their work, which is then discussed in a group.

Legislative plans for health

President Nixon recognises that rapid inflation of medical costs has made the expense of care prohibitive to many Americans. He is aware of the maldistribution of manpower and resources, and the lack of emphasis on preventive medicine. His proposals for a national health strategy are based on a pluralistic system with both private and public centres of responsibility, rather than a monolithic approach that concentrates authority in a single governmental source.

His principal recommendations lie in the areas of organisation and financing:

(1) *The Health Maintenance Organisation*

This consists of any organisation which provides comprehensive health services to a voluntary enrolled population for a fixed contract fee payable in advance (i.e. a voluntary capitation scheme). It could cover a variety of sponsors and is fundamentally based on a group of doctors offering preventive, curative, ambulatory and hospital care for the one fee. Health Maintenance Organisations would be subject to regular evaluation.

Its advantages are seen to be an economic incentive to keep people healthy, and to function efficiently by such means as sharing equipment, delegation to less specialized staff, and keeping costs down by auditing different methods of treatment. This is in contrast to the item-of-service, piece-work basis of Medicaid or private fee payment, which has no built-in incentive to economy.

Other advantages arise from group work to justify its legislative encouragement. These include the stimulus of working with colleagues, a regular work schedule, better opportunities for continuing education, and less financial risk on first entering practice. The Government would provide planning grants to stimulate the formation of Health Maintenance Organisations, and extra funds would encourage their formation in medically deprived areas.

(2) *The National Health Insurance Plan*

This would cover all employees and their families, in part-payment with employers, through private insurance schemes which would have to fulfil basic government criteria. This private insurance would offer comprehensive cover, subject to certain heavy deductable and part-payment expenses being paid by the individual subscriber to the minimal package. These payments would be subject to a ceiling and according to the government white paper, in the most disadvantageous circumstances of a severe illness such a subscriber might have to pay up to 1,500 dollars.

(3) *A Family Health Insurance Programme*

This would be financed by the Federal Government and would replace Medicaid and provide for the unemployed and the self-employed below a certain income. Patients would be allowed by law to opt for treatment by pre-payment through a Health Maintenance Organisation, or they could choose treatment on a fee for service basis.

Four other proposals are before Congress, three being less comprehensive than the government white paper, and the last being the more radical proposals sponsored by Senator Kennedy. He proposes universal comprehensive health insurance for all United States residents, supported by public taxation and administered by the Department of Health, Education and Welfare. His plans also emphasise the development of comprehensive prepaid group practice and other innovative health systems.

These proposals before Congress should soon radically improve health care for the population of the United States.

Discussion

Health care for the poor in the inner cities of the United States, as measured by the usual criteria of mortality and morbidity, is in a parlous state. Americans are fully aware of this situation, which includes fragmented and crisis-orientated medicine often offered without concern for the patient as an individual deserving respect.

This inadequate situation reflects a failure of Government to maintain a momentum towards social change, aiming at fulfilment of the principles of the constitution. The social collapse in the ghetto areas is another reflection of this failure.

In striving to redress these grievances, and to make use of the inadequate resources available, the Americans have started many experiments of interest to British doctors. They have looked anew at ways of working that we have tended to take for granted. Furthermore our health service has a certain rigidity which militates against change for both structural and financial reasons.

The training and use of a wide variety of aids helps conserve professional skills during the shortage of doctors, brings new opportunities for fulfilment to ghetto residents.

The team approach in primary care provokes comparison with Britain. It was noticeable that most United States doctors took medical histories by direct questioning, and laid more emphasis on physical examination and investigation, so that the old aphorism 'Listen to the patient's story—he is telling you the diagnosis' has become rather a lost treasure. This may stem from the physical-science emphasis in American medical education, and the patient's materialistic view of himself. However, where teams had

developed, much of the social history and other events surrounding the illness was collected by aids or public health nurses.

The training of public health nurses to screen patients and undertake developmental assessment is another useful experiment. Conjoint education and discussion for all the workers of the future health team was found to weld a better understanding, and we could well hold meetings between trainee practitioners, student health visitors and district nurses.

It has always been a rule in nature that structure follows function and it was noticeable that where architects had planned clearly defined conjoint areas for one team and its patients, there was an atmosphere of close co-operation between the staff, and a personal relationship with the patients.

The Office of Economic Opportunity neighbourhood health centres must have representatives of the patients on their board of management. Our patient representation is not at this neighbourhood, grass-roots, level and therefore tends to be a formal major grievance machinery. The rapid spread of health centres and group practice across Britain is beginning to limit the choice of the patient and risks creating an impersonal service, although such organisations have other and overwhelming advantages. To redress this disadvantage we perhaps should mould American experience to our requirements and experiment with 'friends of the practice' associations, or other local consultative devices.

One of the experiments that appears in general to be unsuccessful is the use of a doctor to carry out triage. This work method is becoming routinely applied in many emergency rooms, without adequate assessment. Although it is intended to be a method of conserving scarce medical skills, it appears to encourage uncritical methods of work and reduces the patient to a cipher.

The item of service method of payment by the Government and insurance companies has awakened a concern in American medicine for assessment of the quality of care. At the same time prepaid comprehensive group practice has come to review cost-benefit relationships of differing methods of treatment, in order to keep charges down and maximize the partners' profits. This has led to the use of medical audit of patient care and the evaluation of quality of care.

The avoidance of this type of assessment in Britain stems in part from fear by the doctors of the State (a monopolist employer) interfering in clinical matters. The Department of Health circulates general practitioners with the prices of comparable groups of drugs, and annually informs them of their prescribing costs during a month in comparison with other doctors in the area. Costs of different hospitals are also compared.

We could learn both from conducting medical audit and cost benefit studies similar to the Americans, although regrettably no part of any savings from the latter type of investigations would return at present to the doctors. For example the four-doctor partnership in which I work has prescribing costs about £12,000 a year less than the average for the area. Is our treatment as effective? Is prescribing in general practice extravagant?

Hospital work

American prepaid group practice and the Health Maintenance Organisation concept offer services in a vertically integrated way (from preventive, through curative to rehabilitative) and permit doctors to care for their patients in hospital up to the limit of their competence. This method of work is most satisfying and encourages those with hospital privileges to keep abreast in medical education. It also provides extra doctors in hospital at a time when the ever increasing need for medical staff has, regrettably, encouraged migration of many doctors from the underdeveloped parts of the world.

The tripartite structure of the British health service has not in general permitted or encouraged general practitioners to work in hospitals in urban areas. Perhaps the integration of the service under health boards will change this, but such experimentation is only possible in a less rigid and hierarchical system, and if general practitioners are paid for this extra work.

Comprehensive care

Where the Americans lag behind Britain in social engineering they show little desire to learn from our successes, or our mistakes. For example the Carnegie report on medical education (1970) opens with a quotation from a British Prime Minister of the last century, but contains no reference to the Royal Commission on medical education published in 1968!

Now that reasons for the many imperfections of Medicaid are being grasped, there is a swing towards capitation prepayment and Health Maintenance Organisations. Undoubtedly this will be a great advance in that the patient can choose comprehensive care from one organisation. Discussion of Health Maintenance Organisations suggests they will lessen the federal role in planning and management of health programmes (this seems a naive claim), and that the method of payment will be anti-inflationary as economies of scale take effect, and doctors attempt to lower costs in order to improve salaries.

American doctors are a little shamefaced about the recent medical bonanza of fee inflation. British experience showed that a capitation system led eventually to under-use of services, and gave the doctor little incentive to work harder and offer the ever-increasing range of measures which become available to medicine. Doctors found this most discouraging, and the introduction in 1965 of various re-imbursements in addition to the capitation fee has revitalized general practice in Britain—a lesson the Americans could well bear in mind for the future.

Conclusion

The quality of primary health care for the poor depends both on the caring qualities of the society in which they live, and the firm assumption of responsibility by the Government. The United States of America will have been an independent self-governing democracy for 200 years in 1976, which is longer than either France, West Germany or Italy. It has a greater national income per capita than them, but it falls below these countries and Britain in health and social care as measured by recognised indices of health. However, the Americans are now awaking to these deficiencies in their society.

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