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MEDICAL GRAND ROUNDS

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PROBLEMS IN AMERICAN HEALTH CARE: RISING COSTS AND LIMITED AVAILABILITY

[redacted], a 58 year old [redacted] man from the De Sota area of Dallas was first seen in [redacted] one evening in [redacted], 1966 with manifestations of congestive heart failure secondary to arteriosclerotic and hypertensive cardiovascular disease. He had been seen by his private physician intermittently from early 1960, when he was first found to have hypertension, and put on reserpine and a thiazide diuretic. In 1965, he had an acute myocardial infarction and subsequently experienced angina which limited his work capacity as a carpenter. The costs of the 1964 hospitalization of 3 weeks and his subsequent medical care depleted his $3,000 savings. When orthopnea, paroxysmal nocturnal dyspnea and progressive exterional dyspnea began in early 1966, he had to quit work. During 3 visits to his private physician in [redacted] and [redacted] 1966, he was digitalized and given injections of Mercuhydrin, with some improvement in his left-sided congestive failure.

Since he was unable to pay for continued care by his private physician, when his dyspnea worsened and pedal edema appeared, he came to the E.O.R. He was given IPPB, Lasix and additional digitalis and referred to out-patient clinics.

During the next 12 months, he was seen 13 times in the O.P.C. by 11 different physicians. For each visit, he obtained a ride from a neighbor to a bus stop, rode a city bus into downtown and then out to [redacted]. He started from home by 10:00, arrived at [redacted] by 12:30, waited for 30 minutes to 4 hours to be seen by a physician, left [redacted] as late as 6:30 P.M. and arrived home as late as 9:00 P.M. Numerous problems were noted, including digitalis toxicity, hypokalemia, progressive edema, thrombophlebitis, stasis ulcers, a persistent, non-productive cough, and postural hypotension from anti-hypertensive medication.

He was admitted to [redacted] in [redacted] 1967. He remained in the hospital for 23 days, during which time most of his edema was delivered, his electrolyte abnormalities corrected, his blood pressure brought into the range of 145/95. His hospital bill was $2,065.65.

Following discharge he has been followed by the same resident physician in the O.P.C., being seen an average of once every 3 months.

"Few laymen among either the city poor or the well-to-do suburbanites need to be told that the health care system is inadequate and shows signs of breaking down. Quite rightly they are angry, and quite understandably they blame the medical profession. For the poor in the city, there are few private practitioners of medicine; patients in this class must go miles and spend hours in clinics and emergency rooms of hospitals. For patients in the middle class, the rising costs of hospital rooms and drugs, if not the fees of private physicians, make illness a luxury that even they can scarcely afford. For the elderly, despite Social Security and Medicare, these burdens spell medical disaster"

- Editorial, Annals Intern. Med.: 71:655, September 1969.

BASIC CAUSES OF THE PROBLEM

1. Increased complexity of medical care

   a. Availability of life (and disease) prolonging techniques
   b. Growth of specialization

      1) Decrease in use of primary (family) physicians
      2) Increase in use of hospital facilities

   c. Need for ancillary services and personnel
   d. Increased costs of modern health facilities

2. Changing character of population

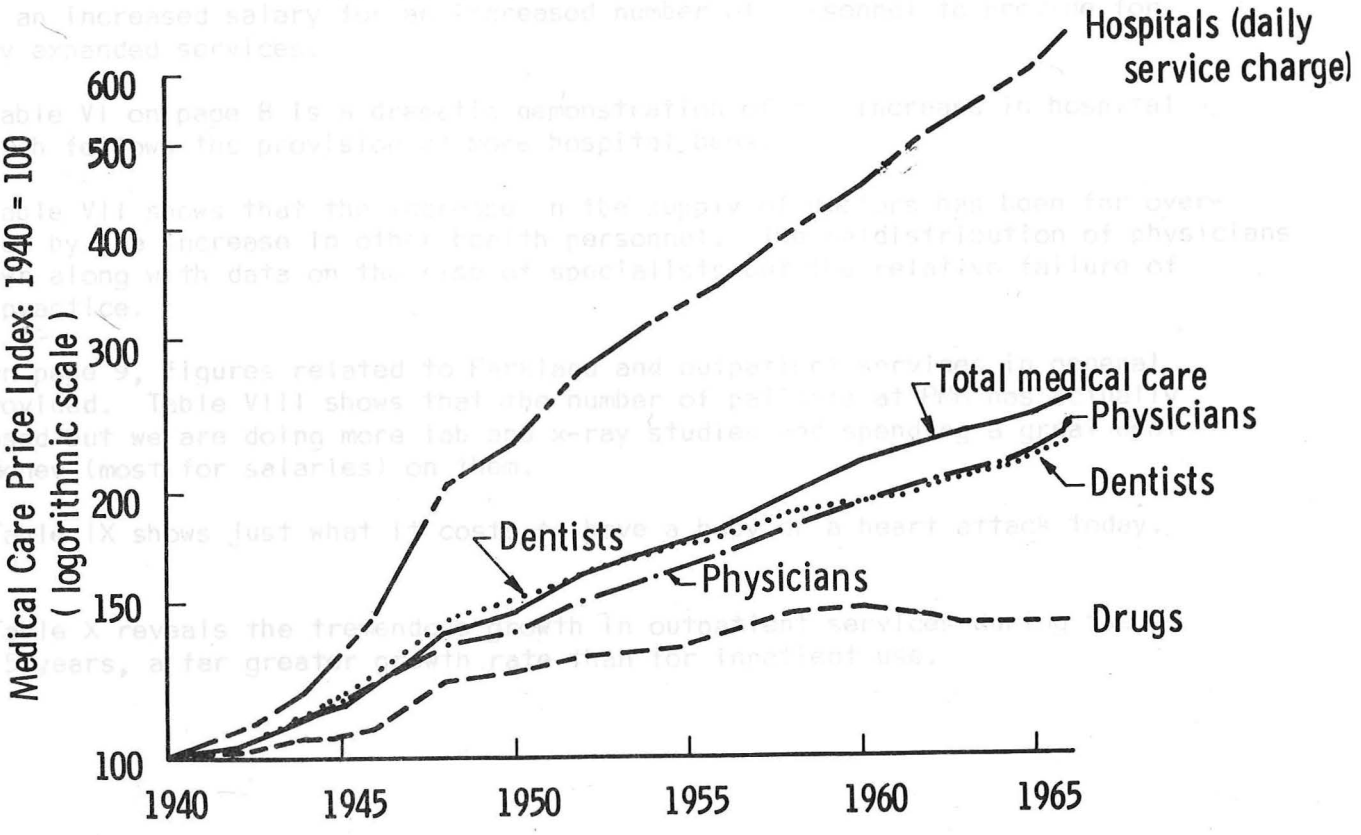
   a. Increased need: old, diseased
   b. Increased demand: urban, educated, exposed, affluent

3. Changing character of disease

   a. Decrease in acute, self-limited disease
   b. Increase in chronic, non-curable disease
   c. Induction of disease by pollution and drugs

4. Changing definition of "adequate" health care (The revolution of rising expectations and increasing health consciousness.)

THE NATURE OF THE INCREASE IN HEALTH COSTS



Source: U.S. Department of Health, Education, and Welfare, Health, Education, and Welfare Trends, 1965, Part I, National Trends, Washington, D.C., 1965, Table S-22.

COMMENTS ABOUT THE TABLES

As shown in Table I, the characteristics of the American population continue to change in ways which increase both the need and demand upon medical care. At the same time, fewer people die of acute diseases at young ages, more live longer to develop more chronic illnesses.

Table II defines some of the differences between health care in the U.S. and other industrialized countries. It should be noted that we have poorer effects of our health care system than the others listed. On the other hand, we have relatively more doctors and more hospital admissions and spend a great deal more money, however the costs are defined. But before being too critical, Ginsberg's comments on page 19 should be noted.

Table III shows some of the factors affecting the receipt of health care in the U.S. This documents what we all know - it helps to be white, rich, young and well-educated. The figures about the effects of insurance are most disturbing in view of the progressive increase in coverage.

In Table IV, the tremendous recent increase in our spending for health care is shown to represent mainly "public" expenditures whereas insurance still covers only a third of private expenses. The increase in prices makes up most of the increased expenditure. Of the greater than 90% of the spending for services and supplies, the portion spent on hospital care has been increasing while physician fees and drugs have actually diminished, relatively.

Table V documents the problems with hospital costs - some increased use but mainly an increased salary for an increased number of personnel to provide for greatly expanded services.

Table VI on page 8 is a dramatic demonstration of the increase in hospital use which follows the provision of more hospital beds.

Table VII shows that the increase in the supply of doctors has been far overshadowed by the increase in other health personnel. The maldistribution of physicians is shown along with data on the rise of specialists but the relative failure of group practice.

On page 9, figures related to Parkland and outpatient services in general are provided. Table VIII shows that the number of patients at PMH has actually decreased but we are doing more lab and x-ray studies and spending a great deal more money (most for salaries) on them.

Table IX shows just what it costs to have a baby or a heart attack today.

Table X reveals the tremendous growth in outpatient services during the past 15 years, a far greater growth rate than for inpatient use.

TABLE I: POPULATION CHARACTERISTICS, U.S.A.

	1900	1920	1940	1950	1960	1965
Age						
Persons over 65 (million)	3.1	4.9	9.0	12.3	16.6	18.2
% of population	4.1%	4.7%	6.8%	8.1%	9.2%	9.4%
Income (adjusted for 1965)						
% under $3,000				32%		18%
% $3,000-$5,000				32%		16%
% $5,000-$15,000				35%		61%
% over $15,000				1%		5%
Education						
Less than 8 years			33%			16%
Completed high school			25%			55%
College graduate			5%			9%
Causes of death						
Pulmonary infections	22%				5%	
Diabetes	1%				4%	
Malignancy	5%				16%	
Cardiovascular disease	8%				38%	

Data from: U.S. Dept. H.E.W., Health Trends, 1965; U.S. Dept. Commerce, 1960 Census of Population; Metropolitan Life Insurance Co., Statistical Bulletin 39:3, 1958, U.S. Dept. Commerce, Statistical Abstracts of the U.S., 1966.

TABLE II: COMPARISONS OF HEALTH CARE

	Sweden	Denmark	Japan	England	U.S.A.
Effects					
Infant mortality (1965)	12	19	18	19	25
Decrease from 1950	9	12	42	12	4
Life expectancy (male)	71.6	70.3	67.7	68.1	66.8
Deaths before age 40	5.4%	6.5%	7.4%	6.9%	8.4%
Deaths between age 40-50	2.9%	3.2%	4.3%	3.8%	5.4%
Provision of Care					
Number of persons/M.D.	960	760	920	840	690
Visits/person/year	3			5	5
Hospital admissions/year	13%			8.8%	13%
Costs (data from 1962)					
Per capita income	$1,420			$1,172	$2,306
Health costs % income	5.6%			4.9%	6.8%
Health costs % G.N.P.	4.9%			4.0%	5.5%
Health costs % private expend.	1.8%			0.9%	4.2%

Data from Blue Cross Reports, 1968; Demographic Yearbook of the United Nations, 1966; B. Abel-Smith, An international study of Health expenditures. W.H.O., Geneva, 1967; O.W., New England J. Med. 269:897, 1963; W.H.O. World Health Statistics Annual 3:18, 1962.

TABLE III: FACTORS AFFECTING THE RECEIPT OF HEALTH CARE

	Non-White	White
Race: U.S., 1963		
Neonatal mortality rate/1000	30	16
Physician visits/person/year	3.2	4.9
Maternal mortality rate/100,000	22.3	89.9

	Lowest 20%	Highest 20%
Income: 1963		
Infant Mortality Rate/1000	37.8	16.2
Days bed disability/person/year	12 days	4 days
Percent receiving Rx who had syncope	56%	82%
Percent receiving dental care during pregnancy	10%	56%

Age	20	40	60	70
Chronic condition, males	32%	51%	67%	80%
Limitation of activity	4%	12%	33%	52%
Physician visits/person/year	3.0	3.2	5.4	5.7
Acute hospital days/person/yr	0.5	0.9	1.6	2.5

	Urban	Rural
Residence (persons age 40)		
Physician visits/person/yr	4.6	2.6

	Less than 8 grades	Some college
Education (1963)		
Seen by M.D. during 1st trimester	67%	88%
Children receiving well-baby care	77%	100%

Insurance	Without	One Policy		Two or more
Hospital admission rates/year	6%	9%		14%
Length of stay/admission	8.8		7.0	
Hospital overstay	6.3%		11.8%	
Surgical procedures/yr	3%		6%	
Tonsillectomies/child/yr	0.7%		2.4%	
Seen by M.D. during year	57%	70%		79%
Prescription charges/year	$8.29		$16.64	
Ambulance used from hospital	8%		27%	

Source: U.S. National Center for Health Statictics, P.H.S. Publication No. 1000, Series 10, 1965; Health Information Foundation, Progress in Health Services 15:3, 1966; Am. J. Public Health 57, March 1967.

TABLE IV: AMOUNTS AND SOURCES OF EXPENDITURES FOR HEALTH

	1940	1950	1960	1966	1967	1968
Total (billions)	3.8	12.2	26.4	42.3	50.6	53.1
Public (billions)	0.8	3.1	6.4	10.8	17.8	19.4
Public (% of total)	21%	25%	24%	26%	35%	37%
Insurance (% of private)		21.1%	27.7%		33.1%	
Total as % G.N.P.		4.5%	5.4%	5.9%	6.4%	6.5%
Per capita (dollars)		$84	$149	$216	$250	$266

	1960-1966	1966-1968
Cause of increases		
Population	18.5%	9.5%
Price	32.1%	55.2%
Other (utilization)	49.4%	35.3%

Breakdown of 1967 Health Expenditures (% of total)

Health Services and Supplies	92.6%	93.7%	92.6%
Hospital care	29.9%	33.5%	35.4%
Physician's services	21.4%	21.1%	20.1%
Drugs	13.4%	13.6%	11.0%
Nursing home care	1.1%	2.0%	3.7%
Research	0.9%	2.5%	3.5%
Construction	6.5%	3.9%	3.9%

Source: Merriam, et al. Social Security Bulletin 31:24, Dec.68; Rice, O.P. and Cooper, B.S., Social Security Bulletin January, 1969.

TABLE V: AVAILABILITY, USE AND EXPENSE OF SHORT-TERM GENERAL HOSPITAL FACILITIES

	1950	1963	1968	1963-1968 % increase
Number of hospitals	5,031	5,684	5,820	2.4%
Number of beds	505,000	698,000	806,000	15.5%
Admissions/1000/yr	110	135	138	2.2%
Hospital days/1000/year	900	1,037	1,168	11.3%
Beds/1000 persons		3.7	4.1	
% occupancy	74%	76%	78%	
Average length of stay (days)	8.1	7.6	8.4	
Personnel/100 census	178	237	272	14.7%
Average salary		$3,639	$4,919	35%
Total expense (billions)	2.1	7.5	14.2	89%
Total expense/patient day	$15.62	$36.83	$61.38	66.7%
Payroll expense/patient day	$ 8.86	$22.79	$36.61	60.6%
Payroll expense % total		62%	60%	
Number with I.C.U.		18%	42%	133%

Source: Hospitals 43:463, Aug. 1, 1969

THE CAUSES OF INCREASED HOSPITAL COSTS

A. Inflation - 5% per year
B. Personnel - 60% of entire hospital expense, i.e. "labor-intensive industry"

1. Increased number of personnel needed

   a. Failure to increase productivity with advanced technology
   b. Need for more highly skilled personnel
   c. Minimum wage laws, shorter work week

2. Increased salary demands

   a. Catch-up with other professional salaries
   b. Increased militancy of nurses and housestaff
   c. Tight labor market
   d. Increased fringe benefits (S.S.)

C. Wasteful practices, excluding numerous "necessary" ineffeciencies such as need for resuscitation and monitoring equipment, ICU, EOR adequate to handle catastrophes, etc.

1. Patient distribution by ability to pay instead of medical needs
2. Uneven utilization of hospital facilities

   a. The errors of Hill-Burton
      1) Overbuilding in rural areas, underbuilding in urban areas
      2) Predominance of new construction over modernization of old facilities
      3) Failure to support outpatient facilities
      4) Failure to develop meaningful area planning

   b. Duplication of services - lack of area planning
   c. Week-end and holiday lulls

3. Reimbursement disincentives

   a. Blue-Cross and governmental payments based on costs of services

      1) Little price control by consumer
      2) Failure to use fixed dollar liability principle

   b. Failure to exert adequate controls on hospital costs
   c. Failure to provide incentive for efficiency

4. Unnecessary utilization - based on socio-economic factors

   a. The more hospital beds, the more they are used without improvement in health status of the community (Table VI)
   b. Requirement for hospitalization to provide insurance payment for care
   c. Increased insurance coverage

      1) Net cost of insurance and profit of carriers
      2) Excessive coverage per individual

5. Failure to include medical staff in planning and running hospitals
6. Padding of lab and x-ray fees, resulting in escalation of these costs
7. Unworkable techniques for control of medical practice (e.g. utilization review)
8. Use of brand-name drugs.

D. Education expenditures ($80 million/year lost on nursing schools)

1. Increasing role of hospitals in training
2. Need for additional housestaff and nurses
3. Longer time of training

E. Capital starvation due to refusal of 3rd parties to pay interest charges

1. Failure to provide funds for depreciation and innovation
2. Inability to buy labor-saving devices

F. Increases scope and complexity of medicine

POSSIBLE DETERRENTS TO INCREASING HOSPITAL COSTS

A. Changes in insurance

1. Benefits limited to cost of services received on a negotiated basis
2. Controls upon costs with incentives for efficiency
3. Coverage for out-of-hospital care
4. Universal coverage

B. Area-wide planning

1. Control over new construction: over $25,000 to build and $18,500 to operate a short-term hospital bed for a year
2. Coordination and sharing of services
3. Use of economy of scale

   a. Cooperative purchasing of supplies
   b. Increased utilization of facilities

4. Anticipate changes in medical needs
5. Involve medical staff and consumers in planning and operation

C. Personnel

1. Increase supply with assumption of training costs by the public
2. Improve efficiency

   a. Increase use of "subprofessional" personnel
   b. Remove artificial barriers to vertical mobility (e.g. certification requirements)

3. Provide workable controls over medical practice using on-going analysis

D. Keep patients out of hospitals

1. Improve out-patient facilities

   a. Comprehensive services, including preventive
   b. Neighborhood services
   c. Transporation to central facility

2. Provide alternatives to hospital care

   a. Home care
   b. Extended care
   c. "Hotel" facilities

3. Group and prepaid practice arrangements
4. Teach comprehensive and preventive care rather than crisis and curative practices

TABLE VI: UTILIZATION CHANGES OF A GENERAL HOSPITAL ASSOCIATED WITH AN INCREASE IN ITS BED CAPACITY (A County in Upstate New York 1957-1959)

	Prior to Expansion 1957	After Expansion 1959	Percent Change
Population of the county	53,614	54,976	+ 2.5
Beds in the hospital	139	197	+41.7
Active physicians on staff	59	64	+ 8.5
Beds per active physician	2.36	3.05	+29.2
Admissions	5,787	6,471	+11.8
Patient-days per 1000 population	738	905	+22.6
Blue Cross patient-days	9,703	13,381	+37.9
Daily Census	108	137	+26.8
Percent occupancy	78	70	-10.3
Obstetrical beds	32	37	+15.6
Obstetrical admissions	1,535	1,483	- 3.4
Birth rate per 1000 population	23.2	22.9	- 1.3
Patient-days in five nearby general hospitals	337,835	340,603	+ 0.9

Source: M.I. Roemer, "Bed Supply and Hospital Utilization: A Natural Experiment", Hospitals, 35:36-42, Nov. 1, 1961.

TABLE VII: THE SUPPLY AND FUNCTION OF HEALTH PERSONNEL

	1900	1920	1940	1960	1969
Number					
M.D.	123,500	151,300	174,500	242,500	305,000
Others	73,600	257,400	692,400	1,139,500	

Distribution (per 100,000 people)	M.D.'s	Nurses
Northeast	179	460
Pacific	166	329
Southwest	106	170
Southeast	94	164

	1930	1950	1965
Nature of practice			
Percent G.P.	83	63	36
Percent Specialist	17	37	64
Percent in Group Practice	1	3	7

TABLE VIII: PARKLAND HOSPITAL STATISTICS

	1964	1968
Services		
Patients admitted	28,729	26,799
Medical service admissions	3,091	3,379
Hospital days	247,742	238,862
Hospital days, patients over 65	33,030	25,670
Percent occupancy	77%	71% (89% on Medicine)
Laboratory tests	1,017,238	1,571,507
X-ray exams	115,104	153,018
Outpatient visits	205,705	229,044
EOR visits	117,589	137,953
Income		
Ad valorem taxes	$6,843,408	$11,286,800
Patient services	$2,013,045	$ 6,241,342
Total	$9,436,035	$18,313, 232
Expenses		
Salaries	$5,820,310	$10,700,432
Total	$9,665,097	$17,270,736

Source: Dallas County Hospital District 1968 Annual Report

TABLE IX: THE COSTS OF HOSPITALIZATION AT PMH

Dx: Acute myocardial infarction - uncomplicated - 15 day hospitalization 8/28/69 to 9/12/69

Room and board (34.00 per day)	$510.00
X-ray - 3 chest	56.25
Oxygen therapy - O_2, IPPB	478.00
Laboratory	224.75
Central supply -VP tray, etc	58.30
Drugs	121.46
ECG	60.00
	$1,508.76

Dx: Uncomplicated term delivery 3 day hospitalization 8/20/69 to 8/23/69

Room and board ($29.00 per day)	$87.00
Delivery room	77.00
Laboratory	45.00
Central supply (pads, etc)	8.25
Drugs	11.45
EOR	5.00
	$233.70
Charges for infant's care	86.00
	$319.70

TABLE X: THE USE OF HOSPITAL OUTPATIENT SERVICES

	1953	1967	% change
Hospitals - inpatient	5,212	5,850	+ 12%
Hospitals - O.P. services	3,212	5,159	+ 58%
Admissions/1000 people	116	138	+ 19%
O.P. visits/1000 people	268	562	+110%
Civilian population	156 million	196 million	+ 25%
Admissions/hospital/yr	3,472	4,613	+33%
O.P. visits/hospital/yr	12,827	21,319	+66%

PRIVATE HEALTH INSURANCE

A. Principles of insurance

1. The unpredictability of risk for the individual
2. A reasonable predictability of the degree of risk for a group. The larger the group, the more accurate the prediction can be.
3. Transfer of the risk from the individual to the group through the pooling of resources
4. Since those who need it most will use it most ("adverse selection of risk"), either coverage must be extremely wide or restrictions must be employed for high-risk populations
5. Practical aspects of present policies
   a. The occurrence of the loss should be infrequent
   b. The expense must be of considerable magnitude
   c. The loss must be beyond the control of the insured
   d. The loss must be measurable and definable

B. Characteristics of group insurance

1. Available to actively working population which is relatively a low-risk group
2. Economy of cost by use of a single contract, saving sales and administrative expenses
3. The group contract holder (employer) usually pays a part or all of the premium
4. The physical condition of the insured is generally not a factor of eligibility
5. Individual's coverage non-cancellable unless he leaves the plan or plan is terminated

C. Types of private insurance

	Cash-Indemnity	Service	Client-sponsored
Example	Mutual of Omaha	Blue Cross	HIP of New York
Sponsorship	Commercial	Hospital association	Community
Form of benefit	Cash indemnity	Service	Service
Delivery system	Unchanged (fee-for-service)	Slightly altered (accredited hospital)	Altered (Group practice)
Benefits	Variable; most limited to major medical	Related to hospitalized illness	More comprehensive

D. The problems with private insurance

1. Limited coverage: On January 1, 1967 with 175 million American under age 65:
   a. 27 million (15%) had no hospital insurance
   b. 38 million (22%) had no surgical insurance
   c. 65 million (37%) had no in-hospital medical expense insurance
   d. 86 million (49%) had no coverage for out-of-hospital tests
   e. 105 million (60%) had no insurance for out-of-hospital physician's fees
   f. 112 million (64%) had no drug insurance
   g. 171 million (97%) had no dental insurance
2. Exclusion of "high-risk" populations
   a. Rural
   b. Disabled
   c. Independently employed

3. Limited payment for covered expenses

   a. 75% of hospital care covered, even higher for surgical expenses
   b. Only about 40% of physician's fees and only about 33% of consumer expenditures for personal health care met

4. Lesser amount of payments for non-surgical physician services

5. The cost of insurance may be as high as 30% of the benefits provided. Blue Cross expenses average 7% but some private companies selling individual policies retain 45% of the premiums

6. Lack of control over costs of services and both adequacy and need of medical practices

   a. Use of "customary and usual" fee concept instead of a fixed schedule of allowances

   b. Dependency upon peer review

PUBLIC HEALTH INSURANCE

A. Types of publicly financed health coverage - though only for 10% of the population. pays for 30% of hospital use.

1. Workman's Compensation - on state basis, covers about 80% of workers
2. Disability - OASDE - Federal, started in 1958; provides benefits after 6 months disability; used by about 3 million workers

3. Medicare

	Part A (Basic)	Part B (Supplementary)
Finance	1/2 employee, 1/2 employer 0.6% of wages	$4/mo from patient and Federal government
Coverage	Compulsory	Elective (97% covered)
Premium	Paid up at age 65	Continuing payment
Benefits	Hospital care (90 days) with $44 deductible, Hospital related benefits	80% M.D. care during hospitalization and after with $50 deductible/year

4. Medicaid (Title 19)

   a. By 1975, adequate medical care must be available to all indigents
   b. Income level of recipients set at 133% of level for AFCD eligibility
   c. Eligibility and degree of coverage decided upon by states but requires at least 7 of 14 categories to be covered
   d. Re-imburses states from 50 to 83% of expenses

B. Problems with public health insurance

1. Fragmented by program and individual state involvement
2. Inadequate controls upon costs and quality of care
3. Increasing demand for health care without improving supply of providers
4. States have too little money to cover expenditures
5. Deficiencies in coverage: no preventive care; almost all for aged and little for children.

Causes of Dependency	Social Security Act Insurance	Social Security Act Assistance	Other Governmental Programs Insurance	Other Governmental Programs Assistance	Private Programs
Unemployment	Unemployment Insurance	Aid to Families with Dependent Children (AFDC)		General Assistance	Supplemental unemployment benefits
Old Age	"O.A." Provisions of OASDHI	Old-Age Assist. (OAA)	V.A., Civil Serv. Retirement	General Assistance	Pension Plans
Premature Death of Provider	"S" Provisions of OASDHI	Aid to Families with Dependent Children (AFDC)		General Assistance	Life Insurance
Illness: Loss of Income	"D" Provisions of OASDHI	Money payments to OAA, AFDC, Aid to Blind & Disabled	Workman's Comp., State Disab. Ins. (4 states)	General Assistance	Temp. Disab. Ins.("accident & health Ins")
Illness: Costs of Med. Care	"H" Provisions of OASDHI (Title XVIII, Medicare)	Title XIX, Medicaid	Workman's Comp. State Disab. Ins. (Calif. only)	General Assistance	Medical Care Insurance

HEALTH CARE FOR THE POOR

I. The barriers to adequate health care for the poor

A. Lack of money
B. Poor health education and motivation
C. Cultural and ethnic values
D. Shortage of facilities
E. Difficulty of access: location, eligibility rules
F. Lack of continuity of care
G. Shortages of health manpower
H. Maldistribution of manpower and fragmentation of services
I. Lack of local planning with participation by the recipients
J. Negative attitudes toward the poor

II. The fragmention of health care for the poor

A. Federal

1. Medicare (Title 18)
2. Medicaid (P.L. 89-97) (Title 19)
3. Comprehensive Health Planning (P.L. 89-749, Section 314e)
4. Neighborhood Health Centers - Office of Economic Opportunity
5. Regional Medical Programs (P.L. 89-239)
6. Categorical aid: Aged, Dependent Children, Blind, Disabled
7. Children's Bureau
8. National Center for Health Services Research

B. Local

1. Dallas County Hospital District
2. Dallas City Health Department

a. Ringworm Clinic
b. Tuberculosis Clinic
c. V.D. Clinic
d. Dental Clinics
e. Nutrition Service
f. Injection Clinics

3. Dallas County Health Department
4. Dallas County Mental Health & Retardation Center
5. Baylor University Dental Clinic
6. Dallas Child Guidance Clinic
7. Sixteen Independent School District Health Programs
8. Planned Parenthood Clinic
9. Visiting Nurse Association
10. U.T. Southwestern Medical School (in cooperation with Hospital District and Health Departments)

a. Family Planning Clinics
b. Prenatal Clinics
c. Well-baby clinics

III. Approaches Toward Improving the Health Care of the Poor

A. Neighborhood facilities

1. Coverage- probably no more than 25,000 total population; well-defined communities
2. Staff

   a. Primary physicians; salaried; substitution for armed service duty
   b. Nursing staff with public health training
   c. Community participation with paid and volunteer aides, home visitations

3. Scope of services

   a. Scheduled office visits
   b. Limited emergency services
   c. Comprehensive, family, preventive practices
   d. Education for improved health practices

B. Community general hospital services

1. Coverage- one or more neighborhood facilities
2. Staff

   a. Broad-based specialists
   b. Ancillary personnel: rehabilitative, speciality services

3. Scope of services

   a. Full, general hospital services on scheduled basis
   b. Complete emergency services
   c. Concentrated, speciality services

C. Regional medical center (Medical school and teaching hospital)

1. Coverage: Entire city plus suburbs plus surrounding region
2. Staff

   a. Broad and narrow specialists
   b. Highly specialized ancillary services

3. Scope of services

   a. Full, general and highly specialized services
   b. Less frequently or predictably needed services

READINGS ON THE HEALTH CARE OF THE POOR

"Ill health lessens the chance poor people have of ever emerging from poverty. The health care that has been offered these people has missed its mark: the rate of disease, disability, and premature death has been higher for the poor than for the rest of the population.

Not enough health services are available to the poor and the shortages are particularly severe in rural areas. Even when services are available a host of barriers keeps them from being used. The person seeking health care is frustrated by problems of fragmentation, impersonality, inaccessibility. A mother may have to journey from one clinic to another and yet a third before her health needs and those of her children can be treated. This may mean hours of travel to facilities which are open only at conventional office hours; long waiting periods in dismal, crowded rooms; abrupt, hurried, and impersonal treatment by an overburdened staff.

The patient may see a different physician each time he goes to the clinic; he and his physician remain strangers to each other, with no opportunity for the development of the understanding and trust which must underlie a therapeutic relationship. The patient is confused by complicated regulation, humiliated by rejecting attitudes, subjected to inconvenience and discomfort, and stripped of his sense of dignity and his privacy. The end result: he seeks health care reluctantly, with more desperation than hope. Sometimes he neglects health problems woefully and sometimes he postpones treatment until it is too late.

Untreated health problems of people in poverty disrupt their total life effort - going to school, getting a job, functioning as members of a family. This disruption affects the entire community."

O.E.O. Neighborhood Health Center Bulletin

"Efforts to meet the problems (of urban poverty areas) have been made... Hospital outpatient departments have expanded, emergency room services have increased, board of health clinics have multiplied, and welfare medical care programs have been developed. Unfortunately, these efforts have taken the form of piecemeal, uncoordinated, stopgap measures designed to meet the most obvious needs of the moment. This has resulted in a complex range of facilities and disease-oriented clinics. When we now look at what is available in our cities we find prenatal clinics, well-child clinics, family-planning clinics, tuberculosis clinics, mental health clinics, disease-detection programs, school health programs, and so forth, none of which are quantitatively adequate. In public health nursing alone, in some cities one can find board of health nurses, visiting nurse association nurses, teacher nurses, and tuberculosis control nurses. Funding may also come from different agencies of local, state, and federal government as well as from private voluntary agencies and foundations.

The dual system of medical care is most obvious when one compares the patterns of obtaining medical care followed by the indigent with those of the more affluent sector of our population. The basis of medical practice is a personal physician who takes responsibility for the total care of the patient, including preventive and curative services, coordination of specialty care, and arrangement for hospitalization when indicated. This concept, however, has not been part of our medical care system for the poorer segment of our society. Approximately 40% of people interviewed in four poverty communities of Chicago indicated that they had no family physician. This segment depends on the numerous facilities listed above for their care. No one person takes the responsibility for coordinating care and evaluating total health needs. Thus, a population with the least sophistication is left on its own to determine the appropriate time and place to seek care.

Lashof, J.C., Ann. Int. Med. 68:242, 1968

THE CHANGING POSTURE OF THE A.M.A.

1. After prolonged and bitter opposition to the concept of government support for health care, the A.M.A., when it realized the program was going to be enacted, insisted upon the inclusion of payment for physician's services in the 1960 Kerr-Mills bill. The original proposal formulated by the federal government was to cover hospital costs only.

   When the demand for more adequate health coverage culminated in the passage of Medicare and Medicaid in 1965, there was no question that physician's fees were to be included.

2. Recent actions by the A.M.A. show its considerable change

   a. Committees have been set up on Community Health and Health Care for for the Poor which are in the process of formulating specific programs of action
   b. The AMA has actively supported the Student AMA's involvement in social action programs
   c. The recent report of the AMA Trustee's "The Physician's Role in Influencing the Costs of Health Care" is enlightened and progressive. However, I do not believe that the use of hospital utilization and medical society review committees will effectively control the over-use of hospital beds or exorbitant Medicare charges that have occurred. Other suggestions in this report include the following:

      1) Evaluation by M.D.'s of hospital pricing policies, "questioning practices that increase costs without commensurate gain in quality of care".
      2) Urging modification of insurance programs to cover office and other non-hospital services to decrease hospital admissions
      3) Taking part in regional and community health planning to eliminate duplication of services and construction of unneeded and expensive facilities
      4) Encouraging experimentation in new methods for the delivery of health care

3. Perhpas the most significant change in the A.M.A. posture is its support for a national health insurance program. The AMA adopted the 1968 report of its Committee on Health Care Financing which states:

   a. Despite their growth, voluntary health programs cover "only one-third of the total of private expenditures and there remain not only substantial numbers of persons who are uninsured, but many who are underinsured.

   b. "Adequate health care should be availaibe to all who need it. Methods of financing health care must aid all individuals to achieve the health services they need". Voluntary insurance programs "must be prepared to disregard traditional limitations and offer comprehensive coverage for essentially all expenses of health care".

c. "Voluntary insurance ... should be encouraged. Government should pay the premium for those for whose care government has assumed obligation."
d. Two proposals for financing this universal program were given, with obvious preference for the second.

1) A community health services fiscal agency, which would cover all people not included under present insurance by collecting a premium which would be the same for all people in the community and paying for all health services rendered to the participants (who would simply charge their services, using a "credit card")
2) "An income tax credit - not a deduction, but an actual remission of a portion of the tax as adjusted to the individual taxpayer's needs. The percentage of credit would decrease as the taxpayer's ability to finance premium charges personally increases, until the individual's tax liability reaches a point where no credit is indicated. Indigents would receive vouchers for the purchase of comprehensive health insurance, financed from the federal general revenues"

Thus the indigent would be given vouchers, the "lower" taxpayers would have as much as 100% of their premium cost deducted from their final tax payment (not from their gross income) and higher taxpayers would have less and less deducted until beyond a certain income level, there would be no tax credit

A reference committee of the AMA Council on Medical Service further stated: "The health care program should be comprehensive in scope of services covered so that it would finance adequate health care and should, therefore, cover preventive care, early diagnosis and treatment of acute illnesses, chronic care, mental care, dental care, prescribed drugs and restorative services, wherever rendered.

"If all persons are to be covered, then participation by all is necessary. Without such participation, the risks of adverse selection could jeopardize the success of the entire program.

"The Council believes our society is moving inexorably, and rapidly, in the direction of a system of financing health care for all persons and believes that the A.M.A. should take the leadership in the development of a program for financing health care that would best serve the public and be acceptable to the medical profession."

GOALS FOR DALLAS

Health Goal #3

"Provide adequate health services, including emergency care, with initial attention to areas where needs are most pressing such as Southeast Dallas. All the health services, especially emergency care, should be easily accessible and should operate at hours convenient to all citizens.

"Interpretation: While metropolitan Dallas is served by many excellent health institutions the delivery of health care and its accessibility to South and West Dallas citizens are often inadequate. These inadequacies stem from lack of funding; manpower and professional motivation; the fixed location of present physical facilities and the lack of adequate transportation to them; the scheduling of programs and clinics for staff convenience; and the traditional deterrents among patients - lack of motivation and ignorance of where and when to obtain health care.

Comprehensive health services include systems to preventive, screening, diagnostic, curative and rehabilitative treatment. Where necessary and feasible, services should be extended to home care.

"To Achieve the Goal: .... appropriate health agencies, including the City and County health departments, should attempt to provide more health services on an interim basis at convenient locations and times. These services should be at strategic locations and associated with one or more hospitals.

Then a master plan would be drafted by the Community Council, City and County health departments, County Hospital District and North Central Texas Council of Governments (NCTCOG) for establishing satellite city and county government health care clinics in areas of pressing need. This plan, which should be completed by December 1973, should consider adequate emergency care, operating hours convenient to patients and availability of transportation.

At this same time a regional plan should be prepared so that every citizen will have rapid access to high quality care. The County Medical Society and SMS should be added to those agencies devising the master plan when this phase of planning is undertaken.

The Community Council, NCTCOG, County Hospital District and the health departments of the City and County should undertake to implement these plans in accordance with time schedules as may be determined by the planning groups.

Health Goal #6

"Form an Area Health Planning Council composed of representatives from, among others, medical schools, hospital districts, hospitals, city and county health departments, medical and health associations and laymen, to help coordinate efforts to solve long-range and growing problems.

"To Achieve the Goal: The development of the comprehensive health-planning effort should be undertaken by the North Central Texas Council of Governments (NCTCOG) which is already significantly involved in planning for environmental health. Its work should build upon the outstanding accomplishments of the North Central Texas Health Planning Council (HPC), which is presently merging its acitvities with NCTCOG.

NCTCOG, as an agency of city, county and other local governmental units, should join in partnership with the State of Texas Comprehensive Health Planning Council and the Department of Health, Education and Welfare (HEW) in developing overall regional planning.

Initial funding for health planning was from federal and local sources. Application for additional federal funding was submitted by NCTCOG prior to September 1, 1969. Funding must be arranged annually, including local funds to match federal grants.

Major steps to achieve the Goal are:

1. Merger of the HPC into NCTCOG by September 1969
2. Development of funding by NCTCOG for comprehensive health planning by December 1969
3. Organization by NCTCOG of a viable comprehensive health planning capability by September 1971.

ALONG COMES AN ICONOCLAST TO DESTROY SOME OF OUR MYTHS -

Ginsberg, E. Facts and fancies about medical care. Am. J. Publ. Health 59:785, May 1969.

This is a most provocative and thoughtful critique of modern medical reform.

"There is a great deal that is wrong with the prevailing system of medical care in the U.S. But this is true of every other major aspect of our national life - education, housing, employment, urban communities, race relations. Democracy means that the rate of reform is determined by the level of discontent of the majority. It does not appear that the American public is ready or nearly ready to abolish the existing system of medical care. Surely the physicians are not. And no politician is offering a radically new program. It looks as if we will be forced to muddle ahead. Even to muddle, we need to be responsive to facts, not fancies."

Ginsberg examines (and virtually destroys) 10 basic beliefs of medical reformers:

1) "Medical care is unique - it involves life or death ... This is true for less than 1% of all services rendered... Medical care will remain what it has always been, largely supportive and ameliorative."

2) "Improved medical care - Key to better health....Admittedly people with inadequate incomes suffer from inadequate medical care, but improved

nutrition and housing might contribute more to their health and longevity than easier access to physicians and hospitals. Many citizens would surely benefit from more and better medical care. But socioeconomic factors and the limitations of current scientific knowledge present real bounds to the promise of medical services for improved health."

3) "Improved medical care is a productive investment....Unless larger expenditures for medical care can be shown to reduce morbidity and mortality, they cannot be justified as effective inputs for improved productivity, however desirable they may be for humanitatian and social reasons."

4) "Good medical care is a right. How can one question this proposition, especially if one recalls the AMA's unyielding adherence to the contention that good medical care is a privelege?....Generalizations about the right of every citizen to a high quality of medical care are easy to formulate but they cannot be translated into policy until their proponents meet four preliminary tests: 'cost out' the program; specify the sources of financing; present evidence that additional public efforts in this realm will yield benefits equal to or greater than if applied to other areas; and delineate how the services will in fact be provided.

5) "Other countries have a more efficient system of medical care....There is no possible justification for infant mortality rates to vary by some 400 per cent within the metropolitan borough of Brooklyn. Much of the difference must be ascribed to poor medical care. But we cannot ignore additional factors such as race, age, martial status, income, housing, employment, which combine and interact to produce this shocking differential. None of the countries of western Europe is confronted with such wide differences among classes and castes, and unless we suceed in eliminating the principal causes of these differences we will not be able to accomplish much by focusing solely on improving the structure of medical care. ....Key indexes not only reveal that other countries lead the United States in national health standards, but they do so at a resources cost for medical care that is proportionately not higher than our own- and absolutely much less. In fact, it is so much less that we should be cautioned against assuming that much higher expenditures for medical care are likely to be reflected in lowered mortality.

6) "The competitive market is a poor instrument for allocating medical resources and distributing medical care.... Assuming that improved medical care is desirable and that the provision of additional good medical services requires the investment of additional scarce resources, it follows that society must rely on some rationing principle to allocate these services. Large-scale governmental financing can shift the relative position of various groups in their access to medical services, but there is little or no prospect - no matter how much money government invests - to equalize the claims of all citizens so that need, rather than income, determines the services rendered to each individual. Rationing according to need would require that government control all of the strategic resources - particularly manpower. Only if the individual physician, nurse, and technician were subject to direct control could such a system be structured. .....Given these overriding geographic, economic, and demographic variables, any serious proposal to establish a more equitable system of medical care within our present society has no prospect of success unless profound structural alterations occur in our free-market economy.

"First, government financial inputs on behalf of the poor would have to be extremely large. Simultaneously, competitive bidding for medical services by the upper and middle income classes would have to cease or at least abate substantially. And finally, decision-making by critical producers of services, particulary physicians, with regard to locus, field, and mode of practice would have to be controlled. With none of these changes even remotely possible, augmented purchasing power in the hands of the poor cannot effect any significant redistribution of medical services. ....Dissatisfaction with the competitive market is justified. Its worst effects can surely be mitigated by judicious interferences. But to contend that it is only a questionof more federal money or the introduction of a comprehensive system of medical insurance that stands in the way of providing adequate medical care to all citizens is social fantasy.

7) "Consumer satisfaction with technical care...Economists have long recognized that the nub of a competitive system is one in which the consumer decides how to spend his money.... However, this model, as many economists recognize, is not adequate to the market for medical care.....While good hospitals can effectively govern the quality of medicine and surgery practiced within their halls, there is little peer control on the outside where traditional ethics constrain physicians to maintain silence about one another's work. As a consequence, many consumers spend a great amount of money in the search for cures that cannot be found; others have unnecessary operations; and more than a few lose their lives as a result of faulty diagnosis and inept intervention. Every major hospital counts among its patients a minority who are there because they have been poorly treated previously, and often seriously. Some patients never have a second opportunity.

Since this is the manner in which the system of medical care operates, the reform movement might assess again the gains that would accrue from facilitating consumer-choice of physician. Those who consider Medicaid an unalloyed boon might rethink all the implications of transferring medical care of the poor out of its traditional site - the clinics of teaching hospitals, at least in large eastern cities, and into the open market of private practice.

Without contending that physicians are greedy or that most patients are hypochondriacal, we should admit that the chief deterrents to over-treatment are the current tautness in physician supply (which enables the practitioner to reduce the number of visits per patient to a minimum at no loss of income to himself) and the fee-for-service payment system (a major consumer constraint).

A critical limitation of the consumer's ability to assess objectively the quality of the care which he receives is a function of the fact that much of the physician's efficacy rests upon his ability to develop a rapport with his patient. While psyche and soma can interact to produce subjective improvement, this is not necessarily the same as relieving the patient of the pathological causes of his symptomatology. A modern system of medical care cannot rest on consumer satisfaction any more than it can rely on the discipline of the medical profession. Here, as elsewhere, reasonable rather than optimum solutions will have to suffice.

8) "Medical Manpower is in short supply....None of the analysts has taken into account that the radical shift toward specialization must be associated with substantive improvements in the structure of medical care, and that it is a travesty to use manpower criteria based on utilization patterns of the 1930's to judge adequacy in the late 1960's. Moreover, factors contributing to enhanced

utilization of physician's time, such as the decline of home visits in favor of office and hospital services, have usually been omitted from these calculations. In addition, the statisticians have paid little attention to the spectacular development of paramedical manpower which has grown much more rapidly than almost any other group in the entire economy.

...It has been suggested that medical care may represent an unusual situation in which the supply creates the demand. It follows that accelerating further the supply of medical manpower (in which the rate of employment from 1950-1965 has grown at about five times the rate for the nation at large) holds little promise of eliminating shortages.

9) The AMA is responsible for many shortcomings in the prevailing system of medical care. It would be difficult to find a professional or trade association that has more consistently or more vigorously supported the wrong side of every public issue in which it had a major stake than the AMA in recent years. For a long time the leaders of organized medicine obstructed the establishment of prepaid group practice units; until recently they were opposed to the expansion of medical education; to this day they have successfully resisted federal subsidization of medical education with the result that entrance into the profession is blocked for most young Americans whose parents do not have ample income. The AMA fought the passage of Medicare every step of the way, and when it capitulated it insisted that the law provide reimbursement to physicians on a fee-for-service basis, which may or may not prove to be untenable - and the former is more likely. Recently it passed resolutions opposing the innovative techniques undertaken by the Office of Economic Opportunity to bring health services to the poor. In addition to blocking practically every effort to modify the existing market structure for medical care, it has moved slowly to provide leadership in such vital areas as improving controls over the quality of medical care that the American people receive.

Despite these indictments - and the list of commissions and omissions could be extended - it is an error to contend that the present structure of American medicine would be vastly different were it not for the conservative stance of the AMA.

Every group in the United States is dedicated to advancing its own special interests; usually these are held to be consonant with the national interest. This holds for the military, business, university professors, lawyers - every group is organized. There is no reason to expect physicians to act otherwise.

....In our social and economic system, in which each organized group operates in the interest of its members, we cannot single out the AMA as the major villain. Although the leaders of organized medicine have failed to lead, so have the leaders of hospitals (governmental and nonprofit), of health agencies, of business and trade unions that are major purchasers, and of other strategic groups, including the progressive leaders of medical education who have recently been singled out as the executors of all the unfinished business of medical reform.

10) Better planning is the answer....The presumption is that planning will continue and that it will chalk up modest victories, but there is little prospect under the present realities of a free society and a free economy that the major participants from physicians to patients will be able to move far or fast to reshape the existing system significantly through planning. And relying on medical schools to assume effective leadership, as the reformers do, is an act of faith, not reason. Historically, no major insitution has been more estranged from the community and its concerns than the university.

It has not been difficult to raise objections to the conventional wisdom about medical care and its overdue reformation. But it would be unsporting not to propose a modest alternative approach to the desideratum of improved health care.

... The urban poor have encountered difficulties in obtaining proper medical attention, but their presence and pressure have stimulated the development within teaching hospitals of comprehansive outpatient departments and the expansion of emergency room services. The present tendency to deprecate these facilities is wrong. Instead, emphasis should be placed on strengthening them and making them more efficient and effective. They hold the best promise of providing care for the urban poor.

Secondly, rather than seeking to attract private physicians into the ghetto or devising ways of enabling the poor to buy services outside of their area, it might prove more sensible to attach to each urban hospital a corps of nurses specially trained to visit families at home for the purpose of screening and referral and once again to serve as health educators.

The third approach would be to improve the diagnostic, referral, and follow-up mechanisms of school health programs in poor neighborhoods. Such an approach offers the urban poor, like the rural poor, much less than the reformers have proposed, but more than they now have and even more than they are likely to have under ambitious programs such as Medicaid or with elaborate community health centers which are likely to collapse under their own weight.

Next to improving medical care for the rural and urban poor, the major challenge is to pre-ent middle income groups from suffereing financial hardships as a result of illness or disability. The best prospect of making significant progress toward this objective would be new and improved programs of catastrophic insurance with reasonable deductibles and co-insurance. Let us be clear. Short of a compulsory system of national health insurance and probably not even then. there is no way to provide all citizens with complete prepaid coverage for all their medical needs. Nor is there any need, unless one takes seriously the claims - and these have never been adequately documented - that much ill health among lower income groups is attributable to a lack of preventive services together with the failure of these groups to seek therapeutic services because of cost. There is merit to these claims but we do not know how much.

The quality of medical care for rich and poor alike is far below what it could be if the professionand government introduced more systematic efforts to monitor the services that are provided in hospitals and in the community. The challenge, however, is to achieve greater comprehension by all parties - the public, the

politicians, and the physicians - of the right of laymen to such protection and the social gains that would accrue. Here is one major line of reform where the prospective costs are small, the prospective gains large. The range of instruments is wide -from statistical reporting and evaluation through continuging education for doctors and greater efforts to associate every practicing physician with a general hospital. More contentious devices such as periodic re-examination for licensure can be held in abeyance until more acceptable reforms have been instituted and evaluated.

It is generally agreed that the present utilization of medical resources is poor because of the perverse ways in which medical services are produced and distributed. Tomention three outstanding shortcomings: community planning and individual hospital management are weak; hospital insurance that is limited to inpatient services tends to inflate costs; and fee-for-service is the most costly method of physician reimbursement. Unless key groups, such as third parties who purchase care and hospital trustees, exercise leadership to improve planning and management, there is little prospect that total medical expenditures can be brought under control. We may be on the way to raising our total annual outlays from $50 billion to $100 billion within less than one decade, with little likelihood of getting much more or much better care than we do now.

Clearly we need innovation in insurance so that coverage can be extended to include diagnostic work performed on ambulatory patients. The minor experiments now under way need to be increased and evaluated, and if the results are favorable new policies should be forthcoming.

Finally, we have had sufficient experience in the last few years to be on guard against infusing new money into the system without exacting a return. Money is leverage and it should be used to extract concessions from the major interest groups so that the prevailing system can slowly be rationalized. Otherwise we will pour more and more money into a system that is characterized by consumer ignorance, a seller's monopoly, inefficiency, lack of accountability - all of which can lead only to further dissipation of resources.

The medical reformer may have disdain for the modest proposals set out above. He will emphasize that the major shortcomings that now characterize the medical care of American citizens will not be eliminated, not even substantially reduced, even if all of the proposals were put into effect. This is granted. But they have been put forward on the following premise: There is no way of equalizing the share of the poor in high quality, privately produced American medicine (the so-called "mainstream"), and we should therefore attempt to improve the services to which they have access. There is no way of removing the financial hurdles to quality medical care for families with modest incomes but the expansion of catastrophic insurance could help. There is no way of using additional public and private resources intelligently unless the planning, organization, and management of the system is improved; and this can come about only as the public, the politicians, and the physicians understand the issues and are willing to act.

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32. Kovner, A.R., et al. Relating a Neighborhood Health Center to a General Hospital. Medical Care 7:118, March-April, 1969.
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33. Multiple authors. Health care for the poor. Hospitals 43:29-112, July 1, 1969.
An entire issue devoted to a few general and many specific proposals for improving health care for the poor.

34. Leo, P.A. and G. Rosen. A bookshelf on poverty and health. Am. J. Public Health 59:591, April, 1969.
A fairly complete bibliography on the subject.

OUTPATIENT SERVICES

35. Report on Conference on Hospital Outpatient Care, American Hospital Association, 1969.
An excellent review of the deficiencies of O.P.C. care with multiple recommendations for improvement. Also has an excellent annotated list of references.

36. Reader, G.G. and M. E. Goss. Comprehensive Medical Care and Teaching. Cornell Univ. Press, Ithaca, N. Y. 1967.
A terribly long description of the Cornell Medical School's attempt from 1952 to 1966 to improve outpatient care and the teaching of comprehensive medicine to fourth year students. There is an excellent discussion of the problems introduced by the advances within medicine during the last 50-75 years to the delivery and teaching of comprehensive care, pages 2-5. A useful guide to those trying to improve O.P.C.

37. Sussman, M.B., et al. The Walking Patient: A Study in Outpatient Care. Western Reserve Univ. Press, Cleveland, 1967.
Another overly-long record of an attempt to improve O.P.C., this one at Cleveland's University Hospital from 1961 to 1966.

38. Snoke, A.W., J. E. Deitrich, E.R. Weinerman, J. H. Knowles and G. Hilkovitz. Panel: Ambulatory Patient Care: Outpatient Clinics and Emergency Clinics. J. Med. Educ. 41:707, 1966.
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39. Lewis, C.E., et al. Activities, events and outcomes in ambulatory patient care. New Eng. J. Med. 280:645, March 20, 1969.
One of the few scientifically valid studies of the effects of a new approach (the expanded use of nurses as active participants) upon the results of O.P.C. care.

40. Miller, W. R. A system to provide and teach comprehensive medical care. J.A.M.A. 189:89, July 6, 1964.
Perhaps its a bit too enthusiastic, but this report of how 5 private hospitals in St. Paul, Minn. provide excellent comprehensive care to indigent patients, ought to be read. Fortunately they only handle about 50,000 visits per year.

41. Rammelkamp, C. H., Jr. and E. M. Chester. A new approach to teaching ambulatory medicine. New Eng. J. Med. 271:349, Aug. 13, 1964.
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42. Walker, J. E.C., et al. An experimental program in ambulatory medical care. New England J. Med. 271:63, July 9, 1964.
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THE ROLE OF MEDICAL SCHOOLS

43. Seldin, D. W. Some reflections on the role of basic research and service in clinical departments. J. Clin. Invest. 45:976, June, 1966.
A strong defense of the position of the Medical School as an institution of learning. "The price for the solution of community service requirements may be the inexorable erosion of academic activity."

44. Hammarsten, J. F. The medical school as a university. J. Lab & Clin. Med. 74:179, Aug. 1969.

45. Haggerty, R. J. The university and primary medical care. New Eng. J. Med. 281: 146, Aug 21, 1969.
Two papers expressing a more moderate view, defining certain legitimate and needed roles of the medical school in the fulfillment of community health needs, while, at the same time, protecting the primary educational role of the university.

46. Beloff, J. S. and E. R.Weinerman. Yale studies in family health care. J.A.M.A. 199: 383, Feb. 6, 1967.
One example of what reference 43 warms against but which is increasingly being advocated and implemented by medical schools across the U.S.