

medical services and communities

The town of Scituate, Rhode Island, has about 10,000 residents. It's a middle-class, exurban town, just 15 miles from Providence, a multi-ethnic city of almost 200,000. Scituate started as a farming community, became home to a number of fabric mills with mill villages surrounded by farms, and saw the mills displaced by the nearby city's need for reservoir space, which caused the mills to close and many farms to be replaced by the forests needed to protect a large watershed. Following that the town returned to farming for 50 years and now is working its way from a rural farming community to a bedroom town of commuters. Scituate once supported four or five general practitioners, one radiologist, and a part-time surgeon, an ear, nose and throat doctor and a psychologist, two or three drug stores with soda fountains, and a district nurse. Now the town has two doctors and one chain drug store. Visiting nurses from one of 11 home health agencies that serve the state come out from Providence when a local hospital sends them to see post-discharge patients, but the nurses typically change every day, and no one knows about or thinks about the poor or the disabled.

Scituate spends about \$15 million a year on schools, and has three elementary schools, one middle school and one high school, about 300 teachers and other school department staff, two school bus companies, and three baseball and soccer fields. The school department creates lots of economic activity for the town, because money earned in Scituate is often spent there – at the barbershop or the hairdresser or the local supermarket. A fair amount of the life of the town is taken up with running the schools, moving children back and forth between home and school, discussing how and what the schools are doing and what they should be doing and how much money is being spent, and how it might be spent better.

On the other hand, about \$80 million is spent annually by Scituate residents on health services, yet very little of that amount affects the

life of the town. As mentioned earlier, there are two doctors and their staffs, comprising in all about 10 people; a chain drug store that employs a few local residents, and one small nursing home for about 50 people, employing 30–40 mostly local staff. Though no one knows for sure, if national spending trends are replicated in Scituate, the populace spends some \$40–50 million on hospital care, at hospitals 10 to 15 miles away; \$15–20 million on medications, \$10–15 million on specialists and tests, which are only available elsewhere, \$8–15 million is spent on health-plan administration, and about \$5 million on primary-care physicians and practices, but less than \$1 million is spent on primary care in Scituate itself. To be sure, there are many healthcare workers who live in Scituate but work in other towns or cities, who bring back considerable income to be spent in the local economy; but that spending, though it helps the local economy, is not earned within the context of local relationships. That is, money is spent in the town but is not earned through local interaction of local people.

Contrast Scituate's situation, for a moment, with the neighborhoods surrounding any major academic medical center in the United States. From Boston to Providence, New York to New Haven to Philadelphia to Baltimore to Atlanta, Cleveland, Chicago, Denver, LA and San Francisco, the story is the same: gleaming buildings ringed by depressed or devastated ghettos. Doctors in white coats and patients from the prosperous white suburbs driving though boarded up streets, with men of color hanging out on street corners. This despite the very real efforts of the academic health centers to reach out to their communities, and work with neighborhood organizations to reduce crime and improve health. What explains this phenomenon? Do academic medical centers emit some toxin that injures the function of communities? Do academic health centers choose to locate in poor neighborhoods because real estate is inexpensive? Were most large hospitals founded many decades ago in locations where urban flight has tended to affect them more than newer facilities? Or, more likely, are neighborhood economic and social functions injured by the presence of academic medical centers, which suck up any of the medical services dollars that could give neighborhoods economic viability and the social capital that comes with it?

The way in which medical services affect local communities and the social capital of small places in the United States is the dirty little secret of the medical economy. The progressive centralization, specialization, and technological sophistication of medical services and medical culture have come at the expense of small places. Once, medical services comprised a substantial segment of the economy of small places. Now, medical services spending and interactions have, quite literally, moved out of town,

undermining the relationships, integrity, and interdependence of small places in the process.

One interesting aspect of the history of the medical services delivery system in the United States is the apparently accidental way in which the centralization of services occurred. It did not have to be this way. In fact, there was a period in which it appeared the United States might develop a local healthcare system that supported communities as it provided medical services to individuals. Let's look at that history, and see what we can learn from it.

1969: COMMUNITY HEALTH IS GHETTOIZED

In 1966 and 1967, Congress created a system of community-based primary-care centers to serve poor rural communities and poor inner-city neighborhoods. Some health policy people, envisioning a healthcare system for the United States as a whole, thought these new Community Health Centers were the building blocks of a healthcare system that could support neighborhoods and rural places as it provided primary care and prevention for all Americans. Had this system been allowed to expand, it could have promoted health for all Americans and likely averted our current crisis. Instead, the American Medical Association fought successfully to limit the community health centers' ability to accept patients able to pay for care. Health Centers, restricted to the care of the poor, failed to become the national health service that the United States so desperately needs.

To understand the story of community health centers in the United States is to understand where we missed the boat, and how we might be able to get back on that boat again.

In 1957, H. Jack Geiger, M.D., a medical student at Western Reserve University School of Medicine in Cleveland, Ohio, spent six months with Drs. Sidney and Emily Kark in the Pholela Health Center in the Natal, South Africa, one of the most impoverished areas in sub-Saharan Africa. The Karks had created an approach to healthcare that recognized the neighborhood or community as a central broker of health. This social construction, called Community Oriented Primary Care, aimed at combining approaches to the health of individuals with the health and integrity of communities by developing programs that strengthened the integrity of the community as it addressed the health of individuals.

The Karks assembled care teams that visited people where they lived, and tried to understand the health needs people really had. They involved local people in developing ways of addressing their own care, educated local people to become health workers, and emphasized ways of addressing local health needs, which were defined by the community itself. Community

Oriented Primary Care aimed to keep control of the healthcare process in the community, as it augmented the civic life of the communities served by health workers by focusing on the things that mattered to communities, and using that focus to build and strengthen the relationships in the community.

Dr. Geiger returned home, finished medical school and trained in internal medicine on the Harvard Service at Boston City Hospital. He then got a job at the Department of Community Medicine at Tufts University School of Medicine and, in 1965, convinced the Office of Economic Opportunity to let him and his colleague Count D. Gibson, Jr., M.D., create the first two Neighborhood Health Centers in the United States, in the Columbia Point housing project, in Boston, and Mound Bayou, Mississippi. Both centers employed the principles Geiger had earlier learned in South Africa. The Neighborhood Health Center movement, now called the Community Health Center movement, created multidisciplinary teams of health professionals. The teams first included internists, pediatricians, obstetricians and psychiatrists. Soon family physicians – a newly minted specialty – pharmacists, visiting nurses, physical therapists, social workers, medical anthropologists, and community people trained to be the voice of community people in and among this group of professionals, enlarged the teams. With all these disciplines, the neighborhood health center teams had the breadth and depth to provide most of the services communities needed, conveniently and close to home and in a form the community could understand and make best use of.

The Neighborhood Health Centers were more than just places for one-stop healthcare services shopping. They were also designed to fuel local economic development, by bringing financial resources into the communities they served. They sought to spur the personal development of the people they served by helping them become the professionals who ran the centers. Finally, the centers encouraged community self-reliance, because community members governed them, a bold experiment in local democracy and community control.

This approach, of using health services to stimulate community-building and create community integrity, caught on very quickly. By the summer of 1966, eight health centers had emerged. Within a year the Office of Economic Opportunity and the Department of Health Education and Welfare funded another 150 health centers all across the United States. Plans were laid for 1,000 centers, serving 25 million people, by 1973. Many people inside the community medicine world understood the value of the health-center approach, and quietly planned to expand the health center model to develop a national health service system for the United States. Such a system would in some ways resemble healthcare systems in Britain

and elsewhere around the world that focus on providing primary care to everyone, but the system would be uniquely American, locally controlled and democratic, and able to improvise solutions for the communities the health centers served.

What Geiger, Gibson, OEO and HEW could not have known was the direction American culture was going to take, and how important the health-center movement might have become in changing that direction. As Robert Putnam has observed, civic life in America was to wither over the following 35 years, a victim of the car culture, of television, and of the expanded working hours of now two-career families.

Although the Neighborhood Health Center Movement was aimed at low-income communities, we see, looking backward, how valuable these centers might have been to the survival of civic life in all communities and how they might have become a national healthcare system for the United States.

But 1967 brought the wrath of the private medical community. The private primary-care doctors, who then still dominated medical politics, correctly understood that the Neighborhood Health Center movement, if made national, would spell the end of the private entrepreneurial practice of medicine. For the private practitioners of 1967, the free enterprise system, and their ability to earn a living as small business people unimpeded by government, was a central tenet of their American faith. These private doctors, fearing the socialization of medicine, fought and almost defeated Medicare and Medicaid in 1964 and 1965. By 1967, they focused their ire on the Neighborhood Health Center movement.

Powerful, but not powerful enough to bury the health center movement entirely, the American Medical Association persuaded Congress to smother the movement by allowing the centers to provide free service only to the poor. Even so, organized medicine worried that the middle class, people with the means to pay for medical service or with health insurance, would use the health centers, and deprive the private medical community of their patient – and income – base. Two years later, in 1969, organized medicine persuaded the government to limit the health centers so that insured, or “paying” patients, could represent only 20 percent of the centers’ patient populations. Although that limit was reversed in 1974, the health centers were marked forever as poverty programs, providing poor care for poor people – no others need apply.¹ Early evidence indicated that the health centers improved the health status of the communities they served and reduced cost through reducing unnecessary hospitalization and emergency room use. Because health centers are required to be accredited by the Joint Commission of Health Care Accreditation and private primary-care practices are not, and because health centers alone receive the Federal

funding needed to create multidisciplinary teams and measure and report the quality of care they deliver, the best possible primary care happens in community health centers. Nonetheless, the business of medicine succeeded in eliminating the threat the health centers posed to it, and the hope that the health centers offered to the country as a whole.

In recent years, most knowledgeable observers note with a mixture of sadness and shame that the best primary care in the United States is practiced at the health centers, although most Americans still wrongly suppose that the Community Health Centers deliver the healthcare of last resort to people who have no other option.