GENERAL HEALTH

# Health care goes into the streets


*The neighborhood centers emphasize family medicine and are tailor-made to fit the needs of the community.*

## By going directly to the problem, OEO health care centers hope to deliver better care to more people

by Jeanne Bockel

The existence of a health gap in the United States is widely accepted. Despite the expression of concern by several Presidents, it is still growing. Criteria such as infant and maternal mortality, used to gauge a nation's delivery of health care, show that the United States' ratings are shockingly poor. In addition, skyrocketing prices have made health care inaccessible to the poor and crippling for the middle class.

**New ways** to deliver health care are sorely needed. One attempt has been launched by the Office of Economic Opportunity in its design of neighborhood health center care for the poor.

According to Dr. Thomas Bryant, associate director for health affairs of OEO, the centers are bringing superior care to the poor; moreover, they may point the way to a radical revision of the nation's health delivery system itself.

OEO statistics show that more than 23 million poor people and an additional 13 million medically needy reside in the United States. Health care normally provided to them, inadequate as it is, has been permeated as well with a stigma of charity. To replace it, OEO designed the neighborhood centers primarily as a research undertaking. But to the slum dweller, the centers have made possible a level of care that just was not available before.

So far, 49 health centers, 13 of which are in rural areas, are being funded in 23 states. But OEO asserts that more centers are needed because, if they were fully functional, they would be sufficient to provide care for a million persons, and OEO is seeking the funds for more.

The Neighborhood Health Centers emphasize family medicine and serve everyone in the target area who is living at the poverty level. They are tailor-made to the needs of the community. As Dr. Bryant says, "It would be of no service to have an English-speaking doctor in a Spanish-American community." In a city, he says, the center may deliver its services to a community; in rural areas, a group of counties may be served. But in either case, a well-organized center can provide services for a population ranging from 10,000 to 30,000.

The largest center, the Watts center in the Los Angeles ghetto, serves about 30,000 people, and employs about 40 to 50 physicians of all specialties. The physicians are divided into teams that include about 4 or 5 doctors, 8 to 10 nurses, social workers, family health workers and other paramedical personnel. Each team serves many families and is able to accomplish what one physician never could. On the other hand, in smaller centers, only three or four physicians, who practice basic medicine, may be employed.

Services are provided on an outpatient basis and the patient receives comprehensive services as preventive health, diagnostic services, at-home care for chronic illness, rehabilitation, dental care, mental health services, drugs and appliances, and ambulance service.

If the patient needs hospital care, that too is arranged by the center. His personal physician continues his medical responsibility for the patient during hospitalization.

The emphasis, however, is on family medicine and the patient is seen not only as an individual but as a member of the family. Many health problems are related to family problems, and such issues as drinking problems, overcrowded conditions and whether both parents are working are explored by the health team.

**The health center** provides the members of its staff the opportunity to deliver health services in a new social climate. Each center has a direct link to a hospital in the community, usually a teaching hospital, and all physicians have staff appointments at the hospital.

The OEO centers are supported for a year or so by OEO grants, but are also designed to use all sources of health funds, encompassing Federal, state and local programs. Medical insurance payments are channeled through the center, as are payments for services to persons enrolled in Medicare. It is hoped that eventually Medicaid alone will be sufficient to support the centers. But many states will not use Medicaid funds for ambulatory care. This increases the cost of Medicaid because it encourages even the best-intentioned



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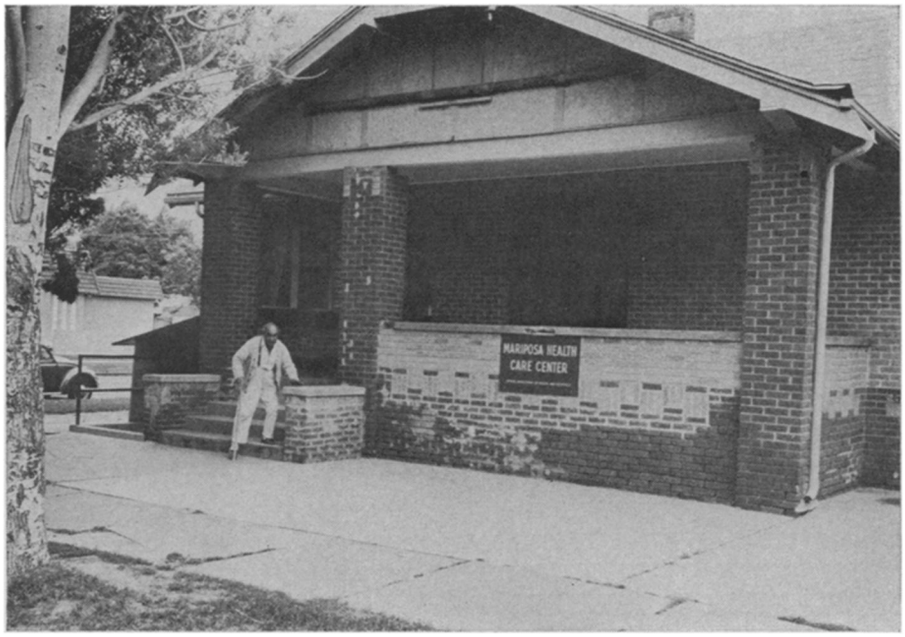
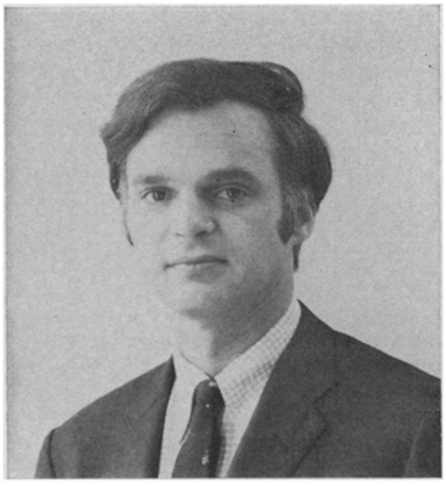
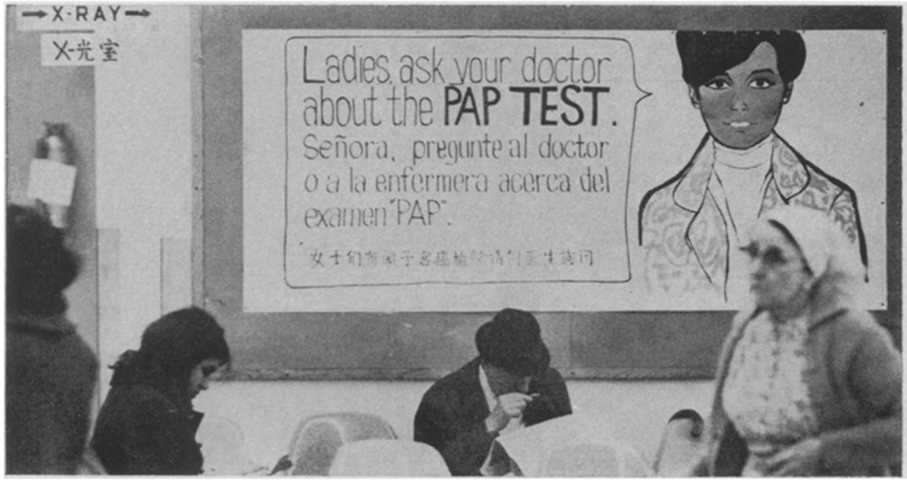
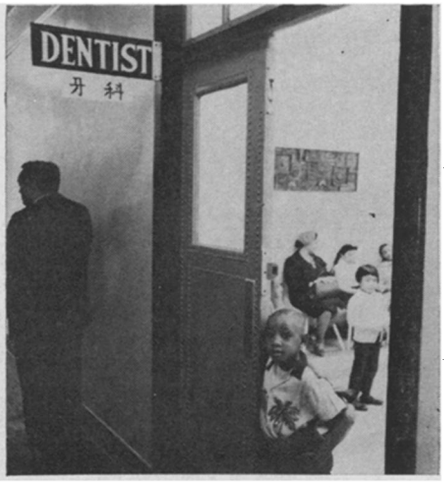



*The results in Denver indicate that neighborhood centers may be the answer.*



*Bryant: Superior care for the poor.*




Photos: OAO

*For the needy, the neighborhood health centers make possible a level of care that was not available before.*

physician to put the patient in a hospital. Dr. Bryant stresses that Medicaid must begin to support ambulatory care because "hospitalization costs money." This is a realization that is already reflected in Presidential policy; the support of hospital construction rather than ambulatory facilities was an issue in President Nixon's veto of the controversial Health, Education and Welfare appropriations bill (SN: 1/31, p. 121).

Dr. Bryant anticipates that Neighborhood Health Centers ultimately will operate without OEO subsidy, as they strengthen their resources through integrating other sources of funds and services.

Although it is not universally accepted that the centers have as yet been successful—any effort to extend them beyond the poverty level is sure to be resisted—Dr. Bryant contends that a few points have been proved. He says that in ghettos, where there is no health care system, centers are the answer. In areas where there are active public health centers with group practice, however, then the answer may be to build on this. "We can't say we've got a model and can spread it around," he says.

**A second** proven point, he says, is that people and institutions can be brought together to focus on the problem. City governments, the poor, physicians and public health workers have willingly joined in helping to provide health care to poor populations, he says.

The impact of success, claims Dr. Bryant, cannot be measured in two or three years. "It would take 20 years of practicing good preventive medicine before that can be done." But some measure of success is already being seen. In Denver, for instance, he believes the center is responsible for the fact that patients are not missing as many days at work, and lengths of hospitalization have decreased.

If OEO's role is to prepare the system for universal health insurance by bringing about the necessary changes in the health care system, the next step, according to Dr. Bryant, is to move into preventive medicine outside the nation's ghettos.

Episodic health care for preventive medicine must be practiced. OEO can bring about this change by next entering the hospital out-patient departments and then into the hospitals themselves. Last summer, OEO made sizable grants to four municipal hospital outpatient departments serving up to 200,000 persons, and hopes to expand the program to 5 to 10 cities in the next year. □