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*Recognizing that health care is not adequately organized for all our people, there are a number of problems that require urgent solution. One is where should the center of health service be located; a second is the role of the consumer; a third relates to the focus of health care. One view on these matters is expressed here.*

# THE NEIGHBORHOOD HEALTH CENTER: THE PRIMARY UNIT OF HEALTH CARE

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IN the general context of the reorganization of health services, this discussion will consider primary health care needs, in particular those of an urban low-income community. The agency through which Dr. H. Jack Geiger and I, together with our colleagues at the Tufts University School of Medicine, have derived our experiences is the Tufts-Columbia Point Health Center. As a neighborhood health center, it can be defined as a comprehensive facility providing or definitively arranging continuous family-centered preventive and curative services under one roof through one door for those of a defined community who wish to use it.[1]

The neighborhood health center represents a radical reorganization intended to deliver better health services. Although the first center is not quite two years old, 41 similar centers have now been funded throughout the United States by the Office of Economic Opportunity. These centers pose a number of issues for discussion and debate. Four will be identified here.

## I. Existing System vs. New Systems: Should There Be Any Reorganization?

Sometimes the plea is made to furnish existing systems of health departments, municipal hospitals, and private doctors with more money and the problems of delivery of better health care services will automatically be solved. Implementation of Title 19 is of course one step in this direction although, unhappily, some of our neediest states will be among the last to take advantage of the program. I agree that dollars will help, but I also believe that experimentation with new social institutions like neighborhood health centers is also essential. There is such a grave deficit of health care services in this country that there need be no fear of competition. There are several reasons for the need for new forms of programs:

a. Existing systems are badly fragmented into preventive and curative, disease-oriented and research programs.

b. There are at present not nearly enough physicians practicing privately in low-income areas and no signs that Title 19 will draw additional practitioners.

c. Technical advances urgently require new forms of multidisciplinary approaches to bring research findings into practice.

In summary, health care is not adequately organized throughout our population, at all socioeconomic levels, but the problems are particularly grave and urgent in our urban and rural low-income ghettos.

## II. Location—in the Hospital or in the Community?

The dominant trend of primary health care for 25 years has been to draw closer and closer to the hospital as the center of health services either by the construction of private offices or by the reorganization of outpatient clinics. The justification has been obvious: the coordination with inpatient care, the accessibility of consultants and specialized equipment, and an increasing ability to apply inpatient standards for quality of care to ambulatory services. Unhappily these same developments have also signified a steady withdrawal of the hospital and its staff from the community needing primary care. This is notably true in large cities where hospital staffs have shown increasing unfamiliarity and inability to serve meaningfully the low-income families they are intended to serve. The differences in ethnicity, education, and economic status between health professionals and the poor—always great—have become even greater in recent years. This gap may be one factor in the low utilization of prenatal clinics and physician-patient encounters at half the national average by poor populations.

In contrast, the neighborhood health center stands in the middle of its community and is affected by the same forces. The rats and mice which have long plagued the Columbia Point Housing Development recently invaded our health center. Altruistic and paternalistic indolence in helping the community turned into an indignant and active sanitation campaign to solve the problem affecting us all. The plight of sick children sent home from school at mid-day to a locked apartment is immediately evident to us. Broken appointments are promptly followed up, for the homes are all nearby. A coordinated home care program is woven into the very fabric of the health center. The technical advances which have made progress possible in hospitals can be equally applied in health centers. With a neighborhood population of 6,000 to 25,000, it is feasible to install an auto-analyzer in the laboratory, modest x-ray equipment, and an adequate pharmacy for the needs of health center patients. Together with the community, we view the wonderful teaching hospitals of Boston as superb technical institutions. We transport our patients there for specified lesion-oriented tasks—and bring them back as soon as the technical procedure is complete—whether it takes one hour or three weeks.

In summary, I believe that primary health care must be optimally rendered in a primary location. The difference between the health center and the hospital is not simply that the hospital is more complex and must serve many functions other than meeting the needs of the immediate community that surrounds it. There is actually a sociologic difference in organization between the two institutions, rendering it much more feasible for the health center to relate in a meaningful way to the community in which it is located.

## III. The Community as Adviser, Participator or Director of the Health Care Agency

For many health professionals, the notion that members of the community served by a health care program should somehow be involved in its operation is an utterly absurd proposal. If coerced, they may reluctantly agree to an advisory board, but it soon becomes clear to the community and to the institution that health professionals are simply not accustomed to taking advice from the laity.[2] I would like to share with you some of our experiences with our community.

Initially we announced our wish to have participation by the community in the operation of the new health center.

The initial acquaintance between the staff and the community flowed from 50 living-room meetings scattered throughout the housing development, in which we explained what the new health center would be like and our wish to be in a partnership relationship with the community. From these meetings there followed the development of an ad hoc committee which would represent the earliest sharing by the community in the development of the health center. Together with the ad hoc committee of the Columbia Point Health Association, we worked together successfully in the opening of the center. The unprecedented utilization which followed thereupon caused a regression in our interests and attention to the Health Association and the board found itself ignored and frustrated as to its functions. It now became increasingly independent of us and sought out advice from the local and state antipoverty agencies as to how it could have a meaningful voice in health center affairs. It became incorporated in June, 1967, and now has a full-time executive secretary. An active grievance committee was formed and committees on personnel policy and review of health center programs are in formation. The board of the Health Association now carefully reviews our expenditures.

Some of our staff have been disturbed on occasion by the complaints voiced by various residents in the community. We have come to learn that in part this represents confidence that we are a permanent community institution and that it is possible to criticize us. Sometimes we are a target for all the bottled-up frustrations at the fragmented and irrational medical care institutions which existed before us. Recently an uninformed newspaper article attacked the health center. I would like to quote the response from a committee of the Health Association. "We are happy with the Doctors, Nurses and Social Workers and the majority of other professionals and nonprofessionals working here. . . . We do have some problems but when recognized they are worked upon and solved through our Grievance Committee. The public should be made aware just how the system is run and how the community is involved and intends to be. Each and every day ways and ideas are formulating for a better communication between staff and residents and we have 75% of our battle won, here."

While many of us entered into a relationship with the community full of doctrinaire notions as to what this relationship should be, a militant and aroused community has turned out to be our best teacher and guide.

## IV. Is the Care Lesion-, Person- or Family-Centered?

Generally, the medical student and house-officer have been oriented overwhelmingly to a lesion-centered environment. The progress which has flowered from such an orientation is obvious but the subtleties and rewards of caring for persons have been poorly represented in our educational process. Even more lacking as models of research and teaching have been systems of family-centered care. Despite the pioneering efforts of many groups, viable models of family-centered care are yet to be developed. We believe that the need for this kind of reorganization is crucial for better health services—especially for multiproblem families.

Initially we began at the Columbia Point Health Center with internists working in an adult health area, pediatricians in a separate children's unit, the nurses working chiefly in the community, and social workers in still a fourth section. We had to rely on ad hoc conferences such as usually found in outpatient clinics and in hospitals to attempt to achieve our family coordination. Just one year ago we reorganized into four family health care groups, each caring for 350

families. Everyone continued to work in his previous setting but each group met once a day for a half-hour to coordinate programs and develop plans for families under active care—and those who should be. Since then two indigenous aides—our family health workers—have been added to each group.

The staff have spontaneously decided that this early experience is so rational that we are now reorganizing the physical structure of the health center into four family health care group areas, each furnishing offices for internist, pediatrician, nurse, social worker, and family health workers. A receptionist and two nurse aides complete the complement. We are simultaneously discontinuing our prenatal, gynecology, and family planning clinics. Instead the obstetrician-gynecologist will spend a half-day each week in each family health care group. The community has learned that if a person does not like the doctor to whom he is assigned he may change to another doctor but his family must all accompany him over to another family health care group. We believe that the concept of the family health care group, with an array of professionals working together in a collegial manner is a far more fundamental approach than debating a single physician versus internist-pediatrician model for family care.

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