Presentation

WAYS AND MEANS OF PROVIDING PRIMARY AND PREVENTIVE HEALTH SERVICES

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DURING THE LAST EIGHT YEARS, I have had the opportunity as Director of the Healthy Children Program to be involved in the development of community-based programs that address the critical issues of access to and cost of health care. This program is a social marketing effort aimed at transferring existing information to community leaders and then giving ongoing assistance to them as they develop their own response to a particular demonstrated need. During these years, I have been involved with over 100 communities. Fifty have developed new initiatives for children. What the Healthy Children Program has demonstrated is that cost-effective models for accessible health care exist and that the communication of these ideas both speeds up replication and generates new ideas.[1]

These communities span the country from New England to the Pacific Northwest. Programs exist in cities as populous as Chicago, Illinois and as rural as Homerville, Georgia. Each is unique because every community has its own resources, its own constraints, and its own political realities. Program design varies greatly and includes ideas such as independent taxing districts for children, public/private partnerships for maternal and child health care, school-based programs for comprehensive adolescent services, and managed home health care for handicapped children. Each program comes with an extraordinary story. I will relate three examples.

Children's referendum

In West Palm Beach, Florida, a mother of two decided to become a lobbyist and went to Tallahassee during the 1986 legislative session. Her mission was to convince the legislature to pass a bill allowing every county in Florida to put on the ballot a referendum for children just as the legislature had done in 1945 for the county of Pinellas. She met with constant discouragement. She was told repeatedly to go home and take care of her family. She refused. When the vote on this particular bill came at the very end of the legislative session, it was 99 in favor, one opposed. She went home happy and exhausted. She was not too exhausted, however, to begin planning for the fall election. She carefully assembled an election committee to run a referendum campaign with children as the candidate. This campaign was well organized and well financed. It had the strong support of many local organizations including the Chamber of Commerce. The proponents of the referendum stressed that nothing was being done to address local issues that many agreed were clear problems. They went on to argue that local initiative was essential if tangible improvement was to occur. In November 1986, a referendum creating a Children's Services Council (CSC) financed by an *ad valorem* property tax passed with 70 percent of the votes cast. In November 1989, the CSC had a budget of $9 million and supported a broad mosaic of children's services. It has been able to initiate new and needed services, to support effective existing programs, and to integrate existing programs when appropriate.[2]

Adolescent OB/GYN services

In St. Paul, Minnesota, the Chief of Obstetrics at the county hospital stated that three things made him angry. The first was that a 15-year-old pregnant patient would come to his hospital in labor without prenatal care. The second was that the same person would come back a year later with her second pregnancy and again, no prenatal care. The third was that there was an adolescent OB-GYN clinic in the county hospital—but no one came. He did something about the problem: he placed family planning services in an adjacent inner-city high school.

This was not accomplished easily. It took 18 months of community meetings and generated significant controversy among parents and faculty. However, the student body leadership came forward at a critical juncture and declared its support. This tipped the scales in favor of clinical services and the school board voted in 1973 for a one-year trial period.

A very important lesson was learned at this point that must not be forgotten. When the clinic opened, it initially offered only reproductive services. It attracted no clients; no adolescent was willing to step forward and risk being labeled as needing such services. The medical staff quickly grasped the problem and closed the clinic while they reconsidered its focus. Eventually they decided to offer a full range of adolescent services. The football team was

enrolled as the first patients, and soon thereafter the majority of students became clinic users. This model became so popular with students, faculty, and parents that today comprehensive services exist in all St. Paul high schools. In addition, selected high schools have instituted day care. This not only enables student parents to complete their education, but also helps them become more effective parents.[3]

This comprehensive program for adolescents has had a marked effect on reducing pregnancy and recidivism rates, increasing graduation rates, and reducing the amount of money that is necessary to support adolescent parents and their children.[4]

Public/private partnership

In Sarasota, Florida, a minister's wife and a public health nurse went to a migrant labor camp outside the city and did not like what they saw. They decided to do something about their concern. What they did was simple, direct, and effective. They put the most malnourished children they could find in their car and took these children to the office of the large pediatric practice in the city. The medical staff had difficulty believing that the community had such poorly cared-for children, but the evidence was indisputable.

The pediatricians decided to open a free clinic in the migrant camp. Almost overnight, all appointments were taken and still many children needed medical care. At that point, the senior pediatrician in the group retired from private practice to become the County Commissioner of Health. His former colleagues soon approached him about their common concern. In 1975, the pediatricians and the County Commissioner drew up a two-page contract that addressed how to provide and finance medical care for children of low-income families. The contract stated that the private practice would provide medical care 24 hours a day for children of migrant workers, children of Medicaid-eligible families, and children of near-poor families as defined by the state. The pediatricians were paid on a per-capita basis. In addition, these families continued to receive the existing support services of the county health department. This contract has been renegotiated every year since 1975.

In 1984, the obstetricians in Sarasota sought a similar contract and received one. Presently, all maternal and child health services in the county are delivered in a public/private partnership. While all the data one would want for a detailed economic analysis are not available, there is enough evidence from patients, physicians, and county officials to indicate that this has been a most welcome and cost-effective approach to caring for low-income mothers and children.[5]

Lessons learned

These are three of many community models that improve access to care for medically underserved children. Much has been learned from these experi-

ments and I would like to comment on these lessons within the focus of this conference—research, health policy, and practice.

The lessons from these programs have important ramifications for a variety of health policy issues:

Access, cost-containment, and quality. Given that access to care, cost-containment, and quality of care are tightly linked, all the projects in the Healthy Children Program were designed to address access and they have succeeded. In addition, the programs also contained or reduced the cost of medical care for the population served. (Admittedly, some communities have better data than others, but none of these programs were initiated as research projects. They all began as a means to fill a gap in a community's services.) When access improved, quality improved as the locus of care shifted from the episodic and fragmented emergency ward to a place and to an individual who then had the opportunity to observe the child over time and in the framework of family and community. This shift in locus of care also underlies why the cost of medical care was contained. Ambulatory care for children is cost-effective in an office or clinic setting; it is not cost-effective in an emergency room.

Financing health services. The majority of these innovative programs have used existing resources to finance health services, with one important exception. Four funding strategies have emerged nationwide:

1. Reorganization of existing public health programs for children. There exist today public health programs aimed at meeting the needs of children. Some of these programs are not targeted on today's needs. If this is the case, there is the opportunity to redirect these resources to meet present needs.

2. Change of site. Programs can be created by parking cars in new locations. Many communities have agencies whose responsibility is to meet the needs of children and adolescents. These agencies may be in a place that is inaccessible or open during times that are inconvenient for community residents. The agencies may also function in isolation, forcing clients with complex problems to make multiple visits to multiple places. By changing where individuals practice, a comprehensive one-stop approach can be created to serve clients during convenient hours. This approach has no budgetary implications.

3. States acting as a foundation. A few states have asked cities and towns to prepare their own proposals for innovative child health programs. If funded, these proposals become part of the state health budget. These states are allowing flexibility in design and understanding of local issues to frame program design. They are

using existing state and federal resources more creatively.

These three approaches all use existing resources to better advantage. The following funding strategy relies on a new funding source: a children's tax earmarked for the broadest array of services.

4. Independent Taxing Districts (ITD). ITD have been in existence in America since 1796. In 1945, this concept was used to create a Juvenile Welfare Board in Pinellas County, Florida. In 1986, when all counties in Florida were given the opportunity to place a children's referendum on the ballot, Palm Beach County quickly voted in favor of a Children's Services Council. Martin and Hillsborough Counties soon followed while Dade and Leon Counties rejected similar initiatives. While this approach is now limited to Florida, many communities in other states are reviewing the feasibility of this idea. Independent Taxing Districts may not be appropriate for every community, but where they exist, they allow the development of new services, the support of existing and effective services, and the integration of clinically similar programs.

Nursing education. Nurses functioning in an expanded clinical role are central to each community program. This has major implications for the future of health manpower planning and the direction of public health nursing education.

Local involvement. Each of these programs was developed at the grassroots level. They were built from the bottom up, not the top down. Individuals and individual initiative are critical. Often only one person has been responsible for a cascade of events. Our country has a vast reservoir of energy and creativity which must be harnessed. People who have lived with a problem often have a workable solution. Since no one approach will solve any of these complex issues, a way must be found to encourage local initiative and thus flexible and workable solutions to complex problems.

There is, of course, wide variation in how each program has been implemented. But three developments must occur and then intersect if the result is to be a viable program. The timetable varies but it is usually 18 to 24 months. Communities with a longer gestation have usually needed to await a change in local leadership. The three-step process includes:

1. An idea. Often this is not well-defined but rather a deep-seated and strongly held concern by a small number of individuals who want to improve available services. This concern can result from a detailed community assessment and the establishment of a

database, but more often it comes from a keen understanding of what is awry in a community and that something needs to be done.

2. A social strategy. The idea that something needs to be done must gain increasing acceptance and support within the community and details of the program need to come into focus. The social skills of the innovators must be such that the circle of support is broadened and local resources identified and secured.

3. Political will. All of the programs involve the politics of change. If political will is absent, nothing will happen. The most common reason why programs have not developed is that political will is lacking.

More research is necessary. It would be helpful to have additional information, particularly concerning economic impact, regarding many of these natural experiments. However, action should not await additional research, for enough is now known about how to provide preventive and primary care services to medically underserved children and how to finance this care. It is of greater importance to understand how this existing body of information can be transmitted in order to allow replication within other communities. This endeavor is known as social marketing—a discipline that is poorly understood and underappreciated by policy makers and the medical profession. Increased emphasis needs to be placed on understanding this methodology and how it may be utilized to address local and national concerns. To repeat, we already have a body of knowledge about what works. It needs implementation, not analysis.

Summary

There exist today a variety of children's health programs that are cost-effective, high-quality, and accessible, and that provide important lessons for communities seeking to improve health care for their children. What is needed is the development of a communications strategy that disseminates this existing knowledge. It has been demonstrated that information in the hands of community leaders results in change and the development of creative programs. Implementation is the goal and social marketing is the methodology.

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REFERENCES

1. Porter PJ, Butler JC. Healthy children: An assessment of community-based primary care health programs for children and their impact on access, cost, and quality. Adv Pediatr 1987;34:379-

409.
2. Special taxing districts for children. Healthy children, 1987. Springfield, VA: Goetz Printing Co., 1987
3. The St. Paul story. Healthy children, 1985. Springfield, VA: Goetz Printing Co., 1985.
4. Edwards LE, Steinman ME, Arnold KA, et al. Adolescent pregnancy prevention services in high school clinics. Fam Plann Persp 1980 Jan-Feb;12(1):6-14.
5. A public-private partnership. Healthy Children, 1982. Springfield, VA: Goetz Printing Co., 1982.