The Professionalization of Neighborhood Health Centers

Since the Federal Government became involved in the delivery of personal health care to a significant part of the civilian population in the 1960s, officials and others concerned with health policy have wrestled with the question of
who could best provide quality service programs for the underserved.

The Office of Economic Opportunity (OEO) attempted to address this question in 1965, when it initiated the neighborhood health center (NHC) program on a demonstration basis. NHCs were developed to provide comprehensive, high quality ambulatory care and be community based with "intensive participation by and involvement of the population to be served." (1).

What happened was something else. Articles in the previous issue of the Health/PAC BULLETIN document the many ways in which this vision was undercut by funding and reimbursement policies and how federal policy has shifted to support for hospital sponsorship of ambulatory care services. They explored the significance of hospital ascendency in this area and its implications for some of the most important and unique features of community health centers. (2, 3)

To provide a broader historical perspective which can illuminate future possibilities, this article will attempt to answer two specific questions: What was the original strategy for institutional sponsorship? When and why did this change?

The Initial Strategy

The first NHC project grants were proudly announced as the beginning of a "new" model health service for low-income, underserved populations, primarily in urban areas. Beyond this immediate goal, the OEO health staff was convinced that when the NHC became widely publicized, its superiority to existing services for all social classes would become manifest and pressure to change the total system would become irresistible.

The initial planning within OEO included the assumption that the existing medical care institutions were in fact a part of the overall problem. Resources, therefore, should be allocated with care to avoid "patching up" that system. As Lisbeth Bamberger Shorr, the staff member most responsible for initiating the NHC program, recalled,

We decided that if OEO was going to spend any substantial amounts of money on health services delivered through the traditional delivery system. (4).

In spite of this conviction, the staff believed that traditional institutions (medical schools, health departments, hospitals) had to be included. Their sponsorship at the local level was considered necessary to recruit professional staff, assure quality of care, and, most important, legitimize the new model within OEO and the broader professional community. OEO Director Sargent Shriver recalled that he was "delighted" when the first NHC application came from "a major university and medical school," commenting, "That was valuable! Very valuable!" (5). Health professionals at the project level got the message. According to Dr. Jack Geiger, co-director of the Tufts University grant establishing the Columbia Point Project,

A key factor in overcoming Shriver's anxiety [about the application]... was that there was a major, quality medical school that they were giving this [grant] to. I don't think that it would have gotten started in any other way. (6).

The OEO staff understood the conflicts inherent in working for reform in concert with established institutions and developed specific policies to insure success. Project directors, though employed in traditional medical institutions, would be chosen who reflected the values and goals of the OEO staff; "citizen participation" through community boards would counterbalance the traditional orientation of the sponsoring institutions; sponsoring institutions would be monitored carefully to prevent diversion of funds to purposes not related directly to the NHC and its goals.

Despite these safeguards, the OEO policy makers realized that the hospital was the nexus of the entire health care system, placing them in the awkward position of an intern who sees the chief surgeon botching an operation. Daniel I. Zwick, a former OEO official, put it this way:

The importance of the hospital was clear from the beginning. Anybody who knows the business... would recognize the importance of the hospital... [We realized] that most of the medical care that was being provided was in institutional settings, and you had to change the hospitals [in order to change the system]. (7).

Continued on Page 6
The American Medical Association is often regarded as slightly more modern than a woolly mammoth caught in Siberian ice, but at its 1979 annual meeting, the AMA's House of Delegates showed signs of thawing out. They approved a new code of ethics that emphasizes patients' rights and allows doctors to solicit patients; gives guarded acceptance to the notion that health maintenance organizations deliver good medical care; and allows physicians to associate with chiropractors.

This country's largest association of doctors still has a way to go. The conclusion that HMO's "seem to be able" to offer lower-cost care than Blue Cross-Blue Shield or other kinds of insurance was sent back for further study by its Council on Medical Services. And its position on chiropractors was at least partly in response to multi-million dollar damage suits by chiropractors' associations—suits that could bankrupt the AMA. Moreover, the Federal Trade Commission has been pressuring the Association to allow advertising.

The most significant change at the AMA may be the dawn of a new political pragmatism—a realization that you cannot stop the national health insurance bandwagon if you are too far behind. "We don't want national health insurance, but we feel we should be in contact with the government so we can influence it," said Dr. G. Rehmi Denton, president of the New York State Medical Society.

Behind all this may be a realization that the AMA image needs sophisticated public relations help. Already a marketing services division with half a dozen marketing consultants pushes the AMA and its line among doctors, and a marketing expert has just been hired to run a membership drive. In the past decade, AMA membership has fallen from 168,000—about half the doctors at that time—to 151,000—only one-third of the country's 453,000 physicians.

Rumors that Pat Boone will be singing a TV commercial, "I'd like to give the world an AMA checkup," appear to be premature, however.

—George Lowrey
(Source: NY Times, July 27, 1980)

Vital Signs

Riders on the crowded anti-regulation bandwagon can happily squeeze over to make room for the American Health Care Association and the National Council of Health Centers (read nursing homes.)

Climbing on with the obligatory independent study, they argue that the Department of Health and Human Services has grossly underestimated the cost of implementing proposed regulations for mental and physical wellbeing in nursing homes receiving Medicaid and Medicare. HHS estimates that these would cost 15 cents a patient day, an annual total of $71 million. The industry asserts that the true cost is $1.35 a patient day, or $534.8 million.

These expensive rights include free association with visitors and other patients; personal privacy; freedom to retain personal property such as books; purchase of items outside the institution; access to one's own medical records; power to form patients' advisory councils; protection against unnecessary physical or chemical restraint; the right to an itemized statement of expenses listing those not covered by the government; and mandatory medical, physical, and psychological assessment of a patient's needs upon admission, with treatment goals and timetables.

If the nursing home lobby arguments prove successful, other groups eager to eliminate waste will no doubt follow with even more ambitious studies. We look forward to "Is the Bill of Rights Too Expensive per Citizen Day?" "Are the Ten Commandments Cost-Effective?" and "The Red Ink in the Golden Rule."

—Ronda Kotelchuck
PROFITS FALLING?
TAKE TUMS.

Like the faces on Mount Rushmore, the giants of the health care industry can be awe-inspiring: Hoffman LaRoche; SmithKline; Ciba-Geigy; G.D. Searle; Revlon. Revlon? That's right; this year the firm that brought you Charlie perfumes will have greater sales and profits from its health care business than G.D. Searle and be within a false eyelash of Richardson-Merrell.

Revlon first moved into health care by acquiring the US Vitamin Co. in 1966. Expansion has brought in everything from laxatives to clinical laboratories, antiacne preparations, and Tums antacid. Its success in winning $3 million in orders for interferon, the promising but unproven anticancer drug, from the National Cancer Institute and a major research hospital has rivals worried Revlon may become the Jordache of genes. For one of these contracts it beat out Abbott Laboratories and Searle.

Management has said it wants to keep this business about half the size of cosmetics, but sales are so healthy that Revlon will soon be what one analyst calls "a major health-care company with a large cosmetics sideline."

The future is limitless; gene splicing could be the answer to dull, lifeless hair.

—George Lowrey

Source: Forbes, August 18, 1980.

THE TOXIC MIND

Much to the amazement of Love Canal residents, a New York State-appointed scientific panel has concluded that there is no "scientifically rigorous" evidence of adverse health effects from the area's toxic waste pollution. The panel was, however, charitable enough to offer a paternalistic recommendation that the hundreds of affected Love Canal residents be moved — not because of any physical danger, but because of the "anguish and anxiety caused by the presence of [the] chemicals."

The panel chairman, Lewis Thomas, is well known in New York City, where he has himself long been an source of anguish to community health activists. Back in the 60s, Thomas, then dean of NYU medical school, was a principal defender of the city's two-class hospital system in which poor (mostly Black and Puerto Rican) in the municipal hospitals, are used as teaching...
material for the private medical empires.

When the advent of Medicaid raised the possibility of merging all the city's hospitals, public and private, into a single, publicly controlled one-class system (see the premier issues of the BULLETIN), Thomas declared:

...To give up... the great tradition of teaching students and young physicians in our municipal hospitals, is absolutely unthinkable. It is our obligation to society to figure out ways to retain, and to use with intelligence and imagination, this great resource.

Through the New York City Health and Hospitals Corporation, which Thomas and other members of the city's medical elite helped shape, private teaching hospitals and medical schools have indeed been able to continue to "use with intelligence and imagination" all those who are poor enough to qualify as teaching specimens.

In the 1970s — perhaps wishing to escape memories of clashes with angry Lower East Side residents — Thomas retreated to Long Island's ultrachic Hamptons area to write best-sellers about the wonders of science. His Lives of a Cell and The Medusa and the Snail, both unabashed glosses for high-tech biomedicine, propelled him into the Carl Sagan league as a national pop-sci spokesman.

—Barbara Ehrenreich

So when Dr. Lewis Thomas finds that the only danger from toxic wastes is that they are mentally upsetting, we should take heed. As we learned in New York City, Thomas's opinions have a way of becoming policy. It may, after all, be far easier to provide mental health services for the residents of Love Canal, Three Mile Island, etc. etc., than to get the polluting industries to clean up their act. And for all we know (science is full of surprises) those broken chromosomes found in the Love Canal residents may be psychosomatic.

—Barbara Ehrenreich (Barbara Ehrenreich is co-author of For Her Own Good: 150 Years of the Experts' Advice to Women.)

CURING THE ULCERS IT CAUSED

SmithKline, the Philadelphia based pharmaceutical company, contributed to what it calls a healthier American society by running a full page advertisement in the May 22, 1980 Wall Street Journal portraying the US as a debilitated garrison society whose very survival is threatened by inadequate military spending.

If SmithKline stockholders wonder why corporate funds are being spent to advertise such ulcer-producing scare messages, it may trace to the company's interest in marketing Tagamet, a SmithKline product reputed to be the only drug that actually cures peptic ulcers. Only available in the US since late 1976, Tagamet already accounts for more than a third of SmithKlines' total revenues and almost half its profits. It is available in over 100 countries and will bring SmithKline an expected $580 million in revenues this year.

Tagamet, in fact, has rocketed to second place world wide among all prescription drugs, second only to Valium which, in its 18th year, should gross $600 million. SmithKline executives predict Tagamet will edge out Valium for first place in 1981, giving future social anthropologists a field day trying to discern what it means when an anti-ulcer drug takes over first place from a tranquilizer.

Tagamet's long-range future appears equally bright. The Food and Drug Administration recently approved Tagamet for long term "maintenance" use, rather than the previous eight week limit. And the current 15 million customers worldwide, according to some estimates, may be only half the pool of peptic-ulcer sufferers.

One possible new pot of gold for Tagamet may lie with Japan. Job security and company loyalty aside, the "industrial miracle" of the East has one of the highest per capita ulcer rates in the world, and Tagamet is not sold there — yet. SmithKline expects to start marketing in Japan in 1981.

The only small, dark cloud on the company's horizon is the possibility that SmithKline may have to defend itself against a coverup suit. A British physician and former SmithKline employee has filed a $40 million suit charging the company with burying his idea for a new drug supplement that, he claims, would have competed with Dyazide, one of SmithKline's fast-selling hypertension drugs. Dr. Maurice Bloch became a consultant for SmithKline in April, 1974, and was prohibited from discussing or publishing his idea even though SmithKline failed to develop it. SmithKline says the suit "has absolutely no validity." Nevertheless, the legal battle could produce ulcers for all concerned.

—George Lowrey
The Professionalization of Neighborhood Centers

Continued from Page 2

Although the reformers believed that any attempt to change the system would ultimately have to confront the hospital, a realistic estimation of their resources and power dictated a prudent short run strategy of demonstrating and legitimizing zones of minimal professional resistance. As Zwick explained,

The strategy that was being developed... was to start outside [the hospital]. If you started within the structured institution you had so many things working against you that your chances of movement were less. So let's start out here with this free-standing neighborhood health center, and develop de novo

Neighborhood Health Centers were initiated when riots, community activism, and other civil rights struggles of the 1960s created a rush to win peace by declaring a War on Poverty.

The medical services in this war were an alternative to private and hospital-based care—culturally compatible, community controlled, preventive, humane, low cost. But NHCs also explicitly functioned as a rallying point, a source of jobs, a center for organizing, and one of the few tangible victories won by communities throughout the nation. Work, staffing, and structure were designed to support all these efforts, not to deliver traditional, narrowly-defined medical services as efficiently as possible. It seemed too good to be true.

In many ways it was. When political winds were blowing our way, we got funding by selling our souls to the devil. Now he feels strong enough to change the rules and demand a refund. The new goal—and myth—is self-sufficiency. But services NHCs specialize in, such as health education, community health, translation, transportation, home visits, social work, and escort services, are not reimbursable. For routine medical services, reimbursement standards for NHCs are similar to those for hospitals and private physicians, but in most cases less advantageous.

When our work in NHCs is judged by narrow criteria, of course we often don't measure up to other health care providers. The Department of Health and Human Services (successor to HEW), generally fails to adequately consider the type of patient we serve, the amount of time we spend on patient education, and the difficulties created by our commitment to hire and train workers from the community.

We don't begrudge our training functions. NHCs are, in effect, the only "schools" in the country for community health workers who come without prior training. In a society which puts a premium on profit and promotion, it is not surprising that many talented staff members go on to acquire formal education and other jobs that are better paid and more complex professionally. Fostering these role models for young people may be one of our greatest contributions to the community. However we and the community also pay a price. Serving as a conduit for minority brain drain means that we are constantly losing our best workers and expending scarce resources to train their replacements.

In a similar situation, other institutions would reduce the scope of their activities. We can't. NHCs must spread themselves thin attempting to provide a broad spectrum of non-medical services otherwise unavailable. We would be the first to admit that a more comprehensive, geographically broader system, with a larger volume of work, could operate much more efficiently. We also know that struggling to play this role lowers the quality of all of our work.

Nevertheless, I am convinced that medical care provided in health centers is far superior to what is offered in hospital clinics, Medicaid mills, and private
without all of those vested interests. (8).

By 1969, the NHC concept and program had become widely broadcast to the public, and institutionalized within OEO and the wider professional community.

**Taking Reform to the Hospital**

The first offensive in this strategy was a series of OEO grants to hospitals to reorganize outpatient departments (OPDs). No section of the hospital fortress appeared more vulnerable. Significant numbers of urban poor still used OPDs as a source of primary care, and experts often pinpointed this as a cause of the financial "crisis" in urban hospitals. These institutions, OEO officials thought, would therefore be more receptive to a plan which would change traditional orientation. Perhaps of greater importance was the new Nixon Administration's

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**Community**

physicians' offices. It is caring, humane, unhurried, friendly: practitioner and patient can communicate. Our nurses, doctors, and physician assistants are generally committed to delivering high quality and comprehensive care, and the structure and community nature of the center encourage their efforts to provide it.

People in the community are aware of these positive qualities and also the deficiencies resulting from budgetary restraints. They generally go elsewhere for quick visits to avoid our inefficiency and long waiting times. If they feel they need longer sessions with the practitioner or a team approach with multiple resources, they come to us. Again, we pay a price for meeting needs: performing more expensive services and not hustling people in one door and out the other are not reimbursable. As funding cutbacks compel service reductions, for example elimination of 24-hour service, many of these patients are forced to seek attention elsewhere—or do without care. These reductions in public funding are known among urban policy specialists as planned shrinkage.

When community use declines, so does interest. Community control is at best excruciatingly painful and very modest; often it is a failure. Local residents are reluctant to remain on a governing board when they are expected to perform difficult and complex tasks and any positive results come very slowly. President Carter went to Charlotte Street in the Bronx, made promises, went home and forgot about them. These people live in our urban Charlotte Streets. They are expected to save community health centers in the midst of laissez-faire urban renewal with its legacy of burnt-out buildings and population dispersal. They see the crippling effects of Medicaid restrictions. They feel the pain of pious demands for self-sufficiency at a time when Medicaid eligibility and reimbursement have been reduced below their previously inadequate levels.

In a sense, the system has won its War on Poverty. We have been defused and diffused. Just maintaining what we have takes all our energy; there is not time or resource left to expend on education, housing, organizing. By giving the community some money tied with regulatory strings, the government has shifted the burden from itself to us. Even as we are slowly strangled by reduced funding, the media and policy makers say that if we do not succeed in hacking our way through the morass of bureaucratic demands to deliver good, inexpensive care to the poorest and sickest within our devastated and impoverished community, it is our fault, proof that community control doesn't work and people can't provide for themselves.

But we don't measure success in their framework. We know that even if NHCs may not be the best way to organize communities or the ideal way to deliver health services, they are the best way we have now, with truly revolutionary potential if they can be kept in the hands of the people they serve.

—Sara Santana
desire for "something different"—programs clearly dissociated from the imprint of President Johnson's Great Society.

As the explosive atmosphere which had spawned the War on Poverty cooled out, OEO also lost its activist emphasis. In the 1967-69 period, physicians gradually replaced non-physicians in key policy-making positions in the NHC program (9). This shift was part of the broader effort to institutionalize the NHC program by replacing personal commitments and loyalties with regulations, structured procedures, and job descriptions. These changes were reflected at the project level, where former civil rights activists were replaced by professional administrators and business managers. As a result, the initial measures taken to guarantee the accountability of the sponsoring institutions disappeared.

The decision to embark on the OPD program in 1969 was not greeted with enthusiasm by the entire OEO health staff. While many physicians on the staff were "very comfortable with hospitals" as grantee institutions (11), non-medical personnel tended to be sceptical. "They were starting with the illusion that...the hospital was going to become a different kind of place," one official noted bitterly, "and they have lost that battle." (12).

Another staff member, Barry Blandford, later described the new program as a "sell-out" in which the OEO's ostensible reform had really amounted to its own cooptation:

I think it sort of changed the philosophy of the program. We were trying to provide services to a given community, where members of that community could have input into the services they were getting...There is no way that you can get the community participation or the neighborhood involvement [through a
hospital grantee] that you were getting with our earlier programs. (13).

Furthermore, as another former OEO official pointed out, the program could actually hurt the poor it was supposed to help:

There was just no way that they could provide the services running directly through a hospital that you were providing through some of our health centers and meet the same costs. I mean it just couldn't be done in a hospital structure. (14).

Despite these concerns, the OPD program became a key part of the overall OEO-NHC effort in the early 1970s. Its efficacy and impact remained limited, however, while NHC staffers struggled to survive budget cuts and transfer to the Department of Health, Education and Welfare.

The notion of hospitals as providers of ambulatory care gained additional support in the mid-1970's from those who decided that since much of the urban, poor population continued to use the hospital for primary care, programs should be tailored to accommodate this pattern. Thus after a significant challenge, the dominance of hospitals in this field is being legitimized once again with the same dubious logic which argued that because smoking is hazardous, the Surgeon General's office should focus its efforts on changing cigarette packaging. Any lingering problems can be blamed on the patient. —Jude Thomas May (Jude Thomas May is an association professor in the Department of Social Science and Health Behavior at the University of Oklahoma Health Sciences Center.)

References
4. Interview, Lisbeth Bamberger Schorr, October 16, 1975. The disposition of the interviews which were completed in our larger study of the NHC is described more fully in the article cited in footnote ten.
5. Interview, Sargent Shriver, June 10, 1976.
8. Ibid.
11. Interview, anonymous respondent.
12. Ibid.

Double Indemnity
The Poverty and Mythology of Affirmative Action in the Health Professional Schools

by Hal Strelnick and Richard Young

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The original neighborhood health center (NHC) model challenged the existing health care delivery system in several ways. Firstly, it was to "reintegrate" the traditional separation between public health and personal health services by defining "health" broadly and providing preventive, environmental and outreach services as well as medical treatment at one facility. Secondly, by providing care to all of the residents of a geographically defined community rather than just to those who fit certain demographic, disease, or poverty categories, health centers were disregarding the accepted boundaries between "public" and "private" medicine. Finally, the inclusion of health care teams and consumer participation in the model was a departure from arrangements which assured professional/physician dominance.

This model of health care delivery did not, however, reach the political agenda from a struggle over health care issues affecting the whole population, but rather, as part of a War on Poverty. Precisely because this model challenged the basic structure of the American health care system, it could only be considered as a part of a separate agenda, one limited to the poor. Even then, established providers such as the AMA and the hospitals were assured that their interests would not be threatened (1). The most challenging aspect of the neighborhood health center model lasted only two years. In 1967 the eligibility criterion was amended from residence in the NHC's catchment area to income below the poverty level (2). This amendment, sponsored by private practitioners, effectively prevented the NHC from serving a mixed income clientele and expanding beyond a poverty population (3).

Neighborhood health centers were first funded in 1965 as research and demonstration projects by the Office of Economic Opportunity (4). In 1968 the Department of Health, Educa-

Continued on Page 19
MURDER IN THE HOSPITAL

East European dissidents certainly have problems at home, but they can usually rely on the American media for sympathetic coverage if they lose their jobs or get arrested. For peasants in a country under the boot of military forces armed and trained by the U.S. government for half a century, it is a different story — or rather no story at all. Papers here don't report natural occurrences, like the sun rising in the morning or the assassination of a few hundred hungry peasants and workers a month in a country where the two percent of the population owning 60 percent of the land must protect itself.

A military junta in El Salvador would have to permit or conspire in something truly outrageous to break the front pages. This it did last March 24, with the murder of Oscar Romero, the country's outspoken archbishop, as he celebrated mass in the cathedral with one of his customary vain appeals for respect for human rights. Before and since, squeamish readers may be thankful that the rare reports of the Salvadorean junta's war against its own people are properly sanitized and confined to the back pages.

One such dispatch last spring indicated that the thousands of victims have included physicians, and in response Salvadorean health workers formed a National Committee for the Protection of Patients, Health Professionals, and Health Institutions. Within a short time, this committee was able to call a strike lasting over a month throughout the country to protest severe violations of health rights.

This May, a group of health workers in New York eager to show support for their beleaguered counterparts formed the Committee for Health Rights in El Salvador. By July, they were able to send a delegation of distinguished physicians and other health workers to investigate allegations concerning militarization of El Salvador's health system, assassination of health workers by the junta, and the active participation by the military in abuses of basic health rights.

The five members of the delegation were Sally Gutmacher, Ph.D., Columbia School of Public Health; Frances Hubbard, B.S.; Sophie Davis, School of Biomedical Education, City University of New York; Walter Lear, M.D., President of the Physicians' Forum; Leonard Sagan, M.D., internist and Fellow of the American College of Physicians; and Arthur Warner, M.D., pediatrician and Fellow of the American Public Health Association. The delegation was co-sponsored by the American Public Health Association, the American Friends Service Committee, and the Physicians' Forum. The delegation interviewed approximately 50 persons in El Salvador, including a surgeon on the junta; the executive committee of the opposition Democratic Revolutionary Front; the United States Ambassador; the past president of the medical association; and representatives of health workers, medical organizations, social service, and relief agencies.

Among the findings reported by the delegation upon their return are:

A. "Following the coup of October 15, 1979, the traditional protection conferred on doctors and patients has been increasingly ignored as military and paramilitary gangs have flagrantly entered hospitals and shot down doctors, nurses, and patients in cold blood. We know of no instance where the Salvadorean Government has identified, prosecuted or punished those responsible for these killings."

B. "Frequently, assassinations have been preceded by the cruellest forms of dismemberment and brutality. Among those gunned down since the coup have been at least nine physicians, seven medical students, and one nurse. Many other health personnel have
"Spies were posted in hospitals to pass information concerning admissions and ward assignments to military and paramilitary groups. Later, hospitals were invaded and patients kidnapped . . . . Neither the motives for these crimes nor the identities of the assassins are ever known."

been wounded as well. We have also been provided documentation about spies posted in hospitals who pass information concerning admissions and ward assignments to military and paramilitary groups. Later, hospitals have been invaded and patients kidnapped. We were told of the use of the mass media to intimidate leaders of the medical strike. Neither the motives for these crimes nor the identities of the assassins are usually known, and those rarely identified are almost always disputed. But it does seem that the same political passions and polarization that divide the country are the underlying cause.

C. "As a result of the closure of the University, the University Medical School no longer operates, and its future is uncertain. It is the only school of medicine in the country and provides the only training for most health worker."

D. "Many physicians, including the former Minister of Health, Dr. Roberto Badilla, have fled the country."

E. "Out of fear of reprisals to practicing physicians, it is reported that even persons who are innocently wounded are unable to receive prompt care."

F. "Violence has had other effects as important as those which follow attacks on health personnel and patients. For example, an uncounted number of persons have fled from their homes out of fear for their lives. We personally visited a camp of over 1,000 of these persons living in totally inadequate quarters. Food, bedding, and medical care were all in critically short supply."

G. "It is obvious even from brief observation that routine violence has led to pervasive fear and tension. We too felt that tension. Every Salvadorean citizen told us not to go out at night. Each morning, the radio announced the bombings of the previous night, and newspapers showed pictures of the mutilated bodies. Clearly, the impact on mental health of all the people is inescapable."

The delegation will publish a complete report of their findings in the near future. Information about the report can be obtained by contacting Dr. Pedro Rodriguez, 146 Central Park West (1F), New York, N.Y.

One specific request that health activists struggling for basic rights and democracy in El Salvador made was that health activists in the United States lock arms with them in solid, active support of their cause. Funds, medicine and personnel are badly needed, they said, but most vital is the involvement of health workers, institutions and professional associations in a campaign to stop the flow of American arms and military aid to El Salvador and make it impossible for the U.S. government to send Marines to repress a popular uprising.

In future issues Health/Pac will provide more reports on the state (or nonexistence) of health rights in El Salvador and other countries, the role of the U.S. Government in these situations, and their implications for health activists here. —Jaime Inclan
WASTE IN SALT TOO

Back when Ronald Reagan was welcoming kids to Death Valley Days, Westerners living in high desert regions could usually expect an occasional wayward coyote to be the most serious disruption of their daily life. No longer. Some farmers and ranchers are getting ready for a showdown with the MX missile. Others are anticipating a life and death battle against massive shale oil conversion projects. Down in New Mexico's quiet, beautiful Pecos Valley, local residents are organizing to repel what may be the most dangerous invasion of all, which comes with the appropriately menacing name WIPP.

The Waste Isolation Pilot Project is designed to hold plutonium and other nuclear waste in six square miles of salt beds two thousand feet underground. In 250,000 years, if the radioactivity has been successfully contained the Department of Energy public relations staff can proclaim that this experiment in permanent waste disposal was a success.

Some people are already dubious. One physicist with the National Aeronautics and Space Administration (NASA) warned that intense heat from the waste would cause the surrounding salt to become hot and soluble, allowing radioactivity to escape. He was fired. Others have pointed out that the proposed dump would be ten miles from the Pecos River, which flows into the Rio Grande. Unless the government hopes this will stop undocumented workers from leaving Mexico or thinks there are too many healthy fish in the Gulf of Mexico, choosing this site appears hard to understand. In addition, if WIPP comes to southern New Mexico, McDonald's hamburgers might soon be hotter than customers expect: the Pecos Valley is one of the country's foremost producers of hay and alfalfa, and its crop is sold to dairies and feedlots throughout Texas.

The fiercest opposition to WIPP has come from the Florencia Land Rights Council, a local grassroots organization composed primarily of poor Chicanos descended from early Spanish settlers and local Indians. For the past three years, the council has organized petitions, demonstrations, and public education programs so successfully that government officials are treating the valley's residents with the caution they might better employ with radioactive wastes: all hearings on WIPP are held 300 miles away in Santa Fe.

Unfortunately, the council doesn't have to rely on abstract arguments alone, since the Florencia area has already been afflicted with Project Gnome. The military has a way of dubbing its operations with pleasant titles, and although Project Gnome may conjure up images of public readings of The Lord of the Rings in local children's libraries, it was actually a 1961 underground atomic blast in the Florencia salt domes. The explosion was, of course, designed to be safe, but radon and other radioactive isotopes escaped into the atmosphere. Area residents are well aware that their cancer rate is above the national average, and they have no desire to risk another experiment which could raise it further.

Despite this vigorous opposition, the valley may yet become what a DOE document honors with the name "National Sacrifice Area." New Mexico's constitution has no provision for a referendum, and its elected officials are not generally noted as champions of the poor—60 per cent of the legislators have a financial interest in the mining industry. There is certainly money to be made from WIPP, which is budgeted at $1.1 billion even before Bechtel and Westinghouse, the major contractors, begin announcing their cost overruns.

Because New Mexico is an "Agreement State," no specific Nuclear Regulatory Commission approval is required for the facility, and the Pentagon has proclaimed it vital to national security. As far as the indigenous people of the Chicano nation are concerned, this invasion is another example of the mentality which ordered the destruction of Vietnamese villages in order to save them.

—From a report by Miguel Carrasco
If You Liked This Issue, You'll Love the Next Six

The Health/PAC Bulletin doesn't have to boast that it's better than the competition; there is no competition. No one else offers independent analysis of health policy issues from prenatal care to hospices for the dying; covers medical carelessness for women and on the job poisoning; offers incisive international reports and lively briefs on domestic health developments.

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Remember, nine out of ten radical doctors recommend the Health/PAC Bulletin for fast relief of health care policy mystification.
CALIFORNIA'S FRIENDLY CCOP

It is no surprise that California, birthplace of the square tomato, was smothered in 290 million pounds of pesticides in 1977, the last year for which statistics are available. However not many people, even Californians, are aware that 35 million of those deadly pounds landed in urban and suburban areas, where 7/8 of the state's population reside. There are individuals who wouldn't touch a sugar-coated cornsmack with a ten foot spoon who spray bug killers on cracks, lawns, and pools with the abandon of a helicopter gunship raiding a free-fire zone in Vietnam. Home use, both personal and professional, of these weapons accounts for over 50 percent of all pesticide poisonings. In addition, even the careful are bombarded by sprays used in parks, buses, and other public places without their knowledge, not to say consent or awareness of the hazards involved.

The hazards are considerable. Many pesticides are believed to cause serious health problems including cancer, sterility, birth defects, mutations, and neurological damage. If they do, those of us who breathe may find out the hard way, since most pesticides have never been tested for pernicious effects except on their intended target.

It could be that just as cockroaches are expected to survive a nuclear holocaust better than humans, we are less vulnerable than they are to roach sprays, but we may not be so lucky. Some day the notion that pesticides are essential, beneficial, and safe may appear as strange and disastrous as the assumption that we can survive a nuclear war.

Despite these dangers, government policies, practice, and regulations are made with virtually no public participation, and do not protect citizens from food, home, and workplace exposure.

Not convinced that what you don't know won't hurt you, a group of California organizations and individuals formed the Coordinating Committee on Pesticides (CCOP) in 1978. It has already grown to include 62 organizations and over 500 individual members. Most of them are concentrated in the San Francisco Bay Area, Sacramento, Santa Cruz, and North...
Pesticide hazards are considerable. They are believed to cause serious health problems including cancer, sterility, birth defects, mutations and neurological damage. Most have never been tested for any effects except on their intended targets.

ern California, but new recruits are increasing in the Los Angeles and Salinas areas. In the process, it has become one of the first successful statewide efforts to link labor, environmental, health, agricultural and consumer groups around a single issue.

CCOP's efforts to publicize the hazards of and alternatives to pesticides have concentrated on the workplace, consumer health, and urban pesticides; all key areas which previously received little attention in the state. Aside from reaching the urban population through legal efforts, media work, organizing, and public education, the alliance is working with the Oil, Chemical, and Atomic Workers and numerous organizations focusing on rural aspects of the pesticide menace, including the California Agrarian Action Project, Friends of the Earth, and the Environmental Defense Fund. Once urban and rural constituencies have been mobilized for the necessary political and economic change, a more rational pesticide policy will become possible. Science has yet to invent a poison that won't make a profit for someone.

CCOP is currently organizing (and seeking funding for) an Urban Pesticides Project to inform, train, and organize target groups of consumers and workers who will begin asserting popular control over pesticide policy at all levels of government. During the first year, these neighborhood and workplace groups will be linked to each other and to the statewide organization.

Berkeley, which has probably had more experience with bugs than any other city in the country, was the site of our pilot project and first victory. After a report by the local committee on pesticides used by public agencies locally and possible alternatives, the city council banned all use of herbicides and four insecticides in the city. The committee is now working with city park workers and the John Muir Institute to create a volunteer force of 30 people which will maintain an Integrated Pest Management program in Berkeley's parks.

—Sharon Miller
(Sharon Miller is a member of CCOP.)
FEVER CHART

WASHINGTON

Public and inner city community hospitals gained a powerful new ally recently when representatives of unions, health professions, community groups, and legal services programs established a Coalition to Save Public Hospitals to press for federal intervention and funding; define a new national policy for public hospitals; and demand a complete moratorium on cutbacks and closures of public, inner city and rural community hospitals. Working with the Coalition for the Public General Hospital formed by members of the American Public Health Association, the new group intends to develop a national advocacy network and aggressively lobby Congress and the Department of Health and Human Services (DHHS).

The alliance certainly has its work cut out. On June 25, 1980, HHS Undersecretary Nathan Stark testified before the Senate Committee on Labor and Human Resources against two bills proposed by Senator Jacob Javits and Congressman Charles Rangel (both of New York) to assist the troubled hospitals. In early September, HHS unveiled a plan to support Medicaid "experiments" which would provide coverage for the millions of medically needy who cannot qualify for Medicaid due to exclusionary eligibility requirements. Because many states have refused to raise their income eligibility ceilings to take inflation into account, 1.7 million fewer people receive Medicaid assistance than two years ago.

HMOs customarily worry about participant withdrawals if their service deteriorates. In this program the participants will worry when they realize the HMO's balance sheet improves as it reduces care, at least so long as the patient remains alive. The government, however, appears unconcerned; a similar New York program sends clients' rent checks direct from the Welfare Office to landlords and the only problem has been the destruction of the South Bronx.

The agreement also includes conversion of Sydenham Hospital to a drug and alcohol rehabilitation center. Community groups and Sydenham physicians have charged that Mayor Koch's refusal to allow emergency room care will needlessly jeopardize thousands of Harlem residents, who will be forced to go elsewhere. The nearest alter-
native, Joint Diseases Hospital, is itself on the verge of bankruptcy and uses a building which has been allowed to deteriorate since a new, modern facility was constructed in midtown Manhattan.

**Detroit**

Mayor Coleman Young has finally succeeded in closing Detroit General Hospital. The city reluctantly opened Detroit Receiving Hospital, which it claims it cannot afford to operate, but Young is negotiating with a consortium of private hospitals to sell DRH to them outright. Since Wayne County General is a two-hour bus ride from the Detroit ghettos, this would leave the city’s poor without any hospital.

The poor people of Detroit are, in effect, subsidizing one of the country’s largest corporations: Mayor Young has “forgiven” over $150 million in back taxes Chrysler owes the city. This gift was the main reason behind this summer’s militant strike by city employees; they don’t feel they should pay because some bright executives were convinced the American public wanted gas guzzlers. No-fault capitalism, anyone?

**Chicago**

Dr. Quentin Young, Medical Director of the embattled Cook County Hospital went out in style early this summer. Young, a veteran of many wars on behalf of the underprivileged, resigned with a sharp denunciation of Hyatt Management Enterprises, which has run the beleaguered hospital under contract since last winter. Embarrassed and nervous Hyatt officials immediately acceded to two of his major demands, cancelling plans to force poor uninsured patients to sign promissory notes so hospital bill collectors could dun them and announcing a recruiting drive to fill the long empty nursing positions.

Young said he is returning to private practice, where he will cheerfully accept Medicare assignment and Medicare patients. He added, to no one’s surprise, that he will continue fighting for public health care —and hopes to have more time to do so now that he is freed of his administrative responsibilities.

**Denver**

Trouble is brewing at Denver General Hospital (DGH), where the administration is refusing to bargain with 2,300 nurses and technicians in the AFT-sponsored Federation of Nurse Health Professionals. The hospital has threatened to radically alter job descriptions and allow untrained and unsupervised personnel to give injections and perform complicated tests.

DGH administrators are also on the offensive against their patients. Last year they shut down its major family practice center, putting even more pressure on the overworked emergency room.

**Los Angeles**

Last year Health/PAC reported the closure of the industry-dominated Los Angeles Health Systems Ageny (BULLETIN vol. 11, no. 1). Some of the same players are back in business as the new HSA stagers to its feet following a craven federal capitulation to pressure from powerful local politicians. HHS designated the county administration as the new HSA, ignoring its close ties to the corruption which plagued its predecessor and a strong, community-backed coalition which hoped to form the health planning body serving the county’s seven million people.

At the HSA board election, it was business as usual. Many veterans of the first agency used their old tricks to dominate the second. Hundreds of Vietnamese refugees were bussed to polling places to “elect” a labor-controlled slate with close ties to the private hospital sector and the construction trades; county labor officials had told independent candidates that they shouldn’t even bother running. It was a splendid victory.

The new President of the LA County Health Planning Commission is one of the staunchest backers of the scandal it replaced.

The new HSA officials are already proving their loyalty to the county government, sitting quietly at their desks while health officials down the hall plan closures of public hospitals and clinics. A top candidate for Executive Director of the new agency is Tony Watson, currently Director of the New York City HSA. Public hospital advocates give Watson extremely low marks for his agency’s whitewash of Mayor Koch’s attack on New York’s public hospitals. Although under his administration the NYCHSA plan offered a token defense of one Harlem hospital, it supported over three quarters of the cuts recommended by the mayor.

—Mark Allen Kleiman (Mark Kleiman is director of the Consumer Coalition of Health, a national alliance of labor, civil rights, senior citizens, women’s religious and community organizations dedicated to greater consumer control of the health system.)

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The Neighborhood Health Center

Continued from Page 10

tion and Welfare funded several neighborhood health centers under a general authorization (314e) for the support of experimental comprehensive health care programs in underserved areas. This was a provision of the Comprehensive Health Planning and Public Health Service Amendments of 1966 (PL 89-749) and the Partnership for Health Amendments of 1967 (PL 90-174) (5). By 1971 there were approximately one hundred and fifty neighborhood health centers in operation across the United States. Two-thirds of these were sponsored by OEO, the other third by DHEW. In 1970 the Nixon Administration began dismantling OEO and moving its programs to other agencies. Between 1970 and 1973, all of the OEO sponsored neighborhood health centers came under the jurisdiction of DHEW (6).

The Nixon Administration desired to reduce the role of the federal government in the direct funding of social programs. In 1973 it attempted to implement a policy which required that health service delivery programs become "self-sufficient," that is independent of federal grant funds (7). With support from key Congresspersons and sympathetic career officials in DHEW (8), grant funds for NHCs continued to be authorized and appropriated. The Health Revenue Sharing and Health Services Act of 1975 (PL 94-63) established a separate categorical grant program for funding health centers, which were renamed "community health centers" (CHCs). Up until this point, centers had been funded under the general 314e authority for experimental health projects.

While it was recognized that "self sufficiency" would not be possible for CHCs unless the health financing structure was changed (9), both DHEW and Congressional health subcommittees continued to expect centers to increase the proportion of their operating budgets which came from third party funds. In the words of a former Congressional committee staff person, members of Congress believed that it was important that health centers "learn to live in the same third party world as everyone else" (10). Unfortunately, this "third party world" is systematically biased against health services in contrast to medical care, and against free-standing, community-based care, while supportive of hospital-based care.

Medicare did not recognize CHCs as reimbursable providers until 1973 and has only granted recognition to centers which have very sophisticated accounting procedures (11). Medicaid is a federal-state program in which participating states are required to provide eight mandatory services. Each state can then elect to provide other services from a group of optional service categories. While outpatient hospital services are one of the eight federally-mandated services, "clinic services," the category under which community health centers are recognized as "providers," is one of the

Despite an ideological credo of "the bigger, the better," an Office of Management and Budget study found that between 1953 and 1973 half of all the innovations came from companies with less than 1,000 employees

optional categories (11). A 1977 Georgetown University Health Policy Center study of Medicaid reimbursement of community health centers found that only 22 states and the District of Columbia recognized CHCs as "clinics" and reimbursed them for services provided (11). This is less than half of the states participating in the Medicaid program.

Community health centers can be reimbursed for specific services (both mandatory and optional), such as physicians' services, family planning, laboratory tests and x-rays when a state does not recognize the centers as providers under the optional category of clinic services. However, each rendered service must then have a separate provider number, and physicians performing each service must submit a separate bill. This method of reimbursement not only complicates accounting, but does not cover the full cost of services provided (11).
At left, the Johnson Administration offers a health care plan. Above center, the Nixon Administration presents its own health policy. At right, Neighborhood Health Centers request additional funding.

Even when CHCs are reimbursed as clinics under a state Medicaid plan, they are not likely to be reimbursed for all of the services that they provide to their patients. The Georgetown University study found that

the "clinic services" category has been used primarily to reimburse traditional medical and dental services (including lab and x-ray), and some non-traditional services, such as family planning and EPSDT, that are mandatory Medicaid services (11).

For example, only five of the 22 states which recognize CHCs as clinics reimburse for outreach services. Six states reimburse for counseling services and seven for health education. Only one jurisdiction, the District of Columbia, reimburses for environmental services.

What consequences does this aspect of the financing system have for the neighborhood health center "model" of comprehensive health services? As pressure was increased from DHEW and Congress to show evidence of greater recovery of Medicaid and Medicare monies, centers were forced to cut back on non-reimbursable services, those very services which made the model innovative. In New York City, for instance, health centers attempted to reduce cost by decreasing staff in "the fringe areas" such as transportation personnel, supportive services and outreach. At the same time attempts were made to maintain staffing levels in the areas of direct services by health care providers—nurse practitioners, physicians' assistants and family health workers. Neighborhood health centers pioneered in the integration of such workers in the delivery of health services (3). Medicare and Medicaid do not reimburse for the services of family health workers. In the case of Medicare, nurse practitioners and physician assistants were not reimbursed for their services at all until the passage of the Rural Health Clinic Services Act in 1977. However, that legislation impacts only on such practitioners in rural health centers (13). Sixteen state Medicaid plans reimburse health services provided by nurse practitioners and/or physicians' assistants, less than a third of all Medicaid programs (11). However, only five of these states allow separate reimbursement for the services of such non-physician practitioners if a physician is not present at the facility at all times (11).

The failure of community health centers to gain recognition as institutional providers for Medicaid reimbursement in many states can be seen as one consequence of the limited political resources that they and their constituents can mobilize in the politics of the state level rate-setting process.

CHCs, of course, share the difficulties with the Medicare/Medicaid system common to all health institutions serving low income populations. As a result of both initial state decisions on eligibility requirements and cutbacks imposed in response to program costs, only one-third to one-half of the population with incomes below the federal poverty level is covered by the Medicaid program (3). Large numbers of individuals served by CHCs have incomes above the Medicaid level but cannot afford to pay for their health care, placing an additional
financial burden on the CHCs.

Approximately two-thirds of the operating budgets of most centers still must come from federal grants awarded by the Bureau of Community Health Services (BCHS) within the Public Health Service (14). The policies of the Bureau have not, however, provided a counterbalance to mainstream reimbursement policy by supporting nontraditional or innovative services. Rather the Bureau’s thrust has been to fund large numbers of small projects in medically-underserved areas in an effort to “fill in the gaps” in the health care delivery system in preparation for a national health financing system (15). In 1975 the BCHS began a “rural health initiative” (RHI) and in 1977 an “urban health initiative” (UHI).

The rural health initiative was an administrative policy of allocating more of the resources of the community health center program to rural areas, of funding smaller primary care projects that were to be integrated with other federal programs, such as the National Health Service Corps, and of targeting resources into areas of greatest need (16). The shift to rural programs was at least in part a decision based on the issue of equity. While more than half of the medically underserved population in the U.S. lived in rural areas, approximately 85% of neighborhood health center funds in 1974 went to urban areas (16). (The War on Poverty, a response to urban riots and the potential role of urban minorities in national politics, had been largely “fought” in urban ghettos.) The decision to fund more programs in rural areas was coupled with a shift in the type of program funded.

Bureau officials believed that smaller programs could be more efficiently managed and, in a cost conscious era, would be less vulnerable to accusations of “waste” than the larger urban programs had been. Smaller scale programs would also be more appropriate to isolated rural settings. A source close to the program suggested that the funding of a large number of health centers in new areas would also have the effect of increasing the number of Congresspersons with health centers in their districts and, thus, broadening Congressional support for the program (16a). Between fiscal years 1975 and 1978, the number of rural health initiative projects increased almost eight times—from 47 in FY 1975 to 356 in FY 1978 (17). While the older and larger community health centers are still receiving a majority (82% of the total of CHC program funds in fiscal year 1978), this proportion has steadily decreased since 1975. The number of larger, “comprehensive” CHCs in 1979 was 156, approximately the same as the number in 1971 (18).

The failure of community health centers to gain recognition as providers for Medicaid reimbursement can be seen as one consequence of their limited political resources.

BCHS literature on the rural health initiative makes it clear that such projects are to integrate not only all federal grant programs in a given community, but also the private and the public sectors and primary care projects and hospitals (19). Those receiving RHI grants can be existing providers who will expand their service area (20), utilize additional manpower, and/or provide a mechanism for the coordination of their services with those of other providers in their area (19). In one Bureau publication seven schematic models of health care organizations are described, varying from one another in the degree of “hospital involvement” in the provision of primary care. The models in which the hospital is closely involved in the health center are described in much more positive terms than is the community controlled model (21).

The first 35 UHIs were funded in 1977, and the following year the number was increased to sixty (17). Urban health initiatives, like RHIs, are small scale projects which need not, according to Bureau literature, provide services other than basic medical care (19). UHIs also are attempts to build a “health system” in a medically underserved area through the integration of federal programs and existing health service providers. A UHI grant may be awarded to a wide range of organizations, including hospitals and group practices. Thus, the health initiatives, conceived at a time of concern about the “rational” use of resources, is an effort to coordinate existing resources and/or to have existing providers service populations which have not previously been served (19). Questions must be raised about how decision-making power will be distributed.

Continued on Page 27
Expanding Sutton's Law

Interviewer: "Why do you continue robbing banks?"
Willie Sutton: I go where the money is."

The trends which May and Sardell describe in the preceding articles are disturbing but not unexpected for those aware of the important historical and ideological forces here that parallel wider developments in the economy. During the post-war era the academic medical center, like the multinational corporation, through expansion and diversification, has been able to capitalize on the changing public funding agenda, be it basic research, facility or manpower expansion, or primary care, by "going where the money is."

As noted above, the neighborhood health center grew from a pilot project within the Office of Economic Opportunity (OEO) in 1965 as part of the Johnson administration's response to the vigorous civil rights movement. OEO developed a strategy that placed their money and agenda for change with creative "change agents" within academic medicine who were to use their grants as leverage for expanding a broad range of both traditional and innovative services into selected poor communities (1). Through their grants strategy, OEO tried to buy legitimacy for and diffuse opposition to its most long-lived offspring — the community health center (CHC). From the beginning, the potential conflicts of interest and agenda for the professional "change agents," the funding agency, the academic medical centers, and the communities were built into the structures of CHCs. The history of CHCs has been the product of the politics of this interaction.

Beginning with the dismantling of OEO by the Nixon administration and the transfer of these programs from OEO to HEW (now,
Health and Human Services), OEO's agenda for changing the health care system has disappeared beneath HEW’s agenda for containing it.01

Since this transition to HEW the comprehensive services mandated by OEO for CHCs have been consistently eroded toward more traditional, strictly medical care. This has meant the loss of training programs and innovative roles, such as the family health worker and health teams. Much of this erosion has been justified under the rubric of efficiency and cost-containment in HEW’s long push toward economic self-sufficiency for CHCs. Thus, services which are not reimbursable in state Medicaid and Medicare plans have been eventually eliminated.

Responding to the AMA’s self-serving criticism of CHCs, HEW, through its Bureau of Community Health Services (BCHS), has increased its productivity demands (based solely on medical visits), while federal grants diminished (compared with inflation) and were spread among many more projects (see Table 1).

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<th>Table 1</th>
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<tr>
<td>Overview of Bureau of Community Health Services Programs, 1974 - 1979</td>
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<tr>
<td>1974</td>
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<tr>
<td>Total Grant Dollars ($ in millions)</td>
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<tr>
<td>Projects Supported</td>
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<tr>
<td>Average Grant Size</td>
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<td>Source: Bureau of Community Health Services Data</td>
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Thus, the innovations created by CHCs are being lost because neither funding nor reimbursement agencies adequately fund ambulatory care or recognize and reimburse the many ancillary services provided by CHCs and their new practitioners (for example, family health workers).

In 1967, HEW called for the establishment of 1,000 health centers to serve 25 million low-income people by 1973 at a cost of $3.4 billion (2). Instead, in 1977 approximately 420 centers were serving 3.3 million people at a cost of $225 million (3). National health insurance, anticipated by the HEW planners to rationalize their push toward economic self-sufficiency for CHCs, remains as distant as ever. Funds from Medicare and Medicaid in 1975 actually covered only 10 to 20 percent of operating costs at most centers (4).

For many years the centers were caught in a double bind: while mandated to serve all low-income people, in 1969 under pressure from private practitioners and the AMA, they were limited to 20 percent paying registrants. Thus, “poor people’s medicine” was legislated, making a transition to economic self-sufficiency impossible. Inflation and reduced federal support led to cuts in CHC services, hours, and access and forced fees upon formerly free care. It became inevitable that many low-income people would return to the hospital emergency rooms and OPDs for their care. These constraints upon CHCs have now been used to rationalize shifting more resources back towards the academic medical centers and teaching hospitals. Claiming that poor patients, armed with their Medicaid cards, are “voting with their feet” in their continued and increased use of hospital ambulatory facilities, legislators and hospital lobbyists are proposing to fund “re-organized” hospital OPDs in apparent direct competition for monies with CHCs. Private philanthropy, uninterested in underwriting long term projects, has turned to a grant formula which examines their short term return on investment, best delivered by the “blue chip” teaching hospitals.

The historic process has come full circle. CHCs were created so that poor people would no longer be “forced to barter their dignity for health care” at teaching hospitals (5). Yet, CHCs were sponsored and legitimized by those very teaching hospitals for overhead and expansion. Now, mandated by legislation which requires consumer majorities on their boards of directors, CHCs have become largely independent, community-controlled entities. The Javits Amendment—the Health Services and Centers Amendments of 1978 (PL 95-626)—to the Public
Despite the success of community health centers in reaching and serving people in impoverished communities, they have been burdened with an undeserved image of costliness and inefficiency.

Health Service Act would recapture this source of federal support for hospitals by making them eligible for the funds which currently support CHCs.

This development has been supported by the influence of the Robert Wood Johnson Foundation which has helped shape HEW policy in matching its money to certain HEW-sponsored demonstration projects. The foundation, presided over by a former dean of Johns Hopkins medical school, perpetuates the prejudices of academic medicine against community control. Thus, it has funded the "re-organization" of 15 teaching hospital OPDs and ten urban, primary care networks based in hospitals. These would employ National Health Service Corps (NHSC) personnel, which requires by law consumer-majority governance bodies absent at such hospitals. Thus, after a short hiatus, the medical empires are back pursuing the control of the federal dollars supporting primary care.

Two important social costs will be borne by the public if this trend continues, as noted by Berkson (see previous BULLETIN). First, innovation will be stifled. Despite ideological credos that "the bigger, the better," an Office of Management and Budget study found that between 1953 and 1973, half of all major innovations came from companies with less than 1,000 employees. Yet, only four percent of federal funding goes to these smaller, more innovative firms (6). This parallels the growing trend toward support of large medical institutions over the smaller, community-based centers and hospitals. Elsewhere in the economy, this is called corporate monopolitization.

In health care, however, the media portrays any developments in high technology as genuine innovation and glorifies the corporate giants that produce "new, revolutionary" discoveries that are often no more "new" or "revolutionary" than the other consumer products so-advertised on television. Just as artificial needs are created by advertising, so too is our subjective ex-
experience of the scarcity of personal, primary care ("how do I find a family doctor?") and vulnerability to an increasingly hazardous environment ("is there anything which does not cause cancer?") subverted. This results in inappropriate demand for high technology, falsely-elevated expectations, misuse of existing services, and growing costs.

More important are the increased direct costs that would result from shifting greater support to hospital-based outpatient services. One of the major successes of CHCs has been their documented reduction upon hospital days for the populations they serve (7). While in the interest of the public purse, this cannot be in the interest of hospitals dependent upon high occupancy rates for their financial well-being. Their interests would control the proposed services. In addition, costs for identical services are likely to be higher in teaching hospitals while the quality is the same or superior in CHCs (8). The basic contradiction between the federal policy promoting cost-containment and its support of trends toward basing more ambulatory services in hospitals is readily apparent, suggesting the political influence of the medical empires.

Despite the success of CHCs in reaching and serving people in impoverished communities, they have been burdened with an undeserved image of costliness and inefficiency, frequently unfavorably compared to the costs of care from the very private sector which abandoned these communities (4).

CHCs may, in fact, be the only providers in the health sector which have successfully reduced costs! HEW estimated that the annual total expenditures per person served by CHCs was $238 in 1974, but only $204 in 1975, while the national average rose from $214 to $240 for comparable services (4). Since 1975 BCHS projects (CHCs, NHSC sites and migrant worker programs) have shown further reductions in costs and improvements in productivity and efficiency (see Table 2). Davis and Schoen estimated that when the cost saving resulting from reduced hospitalization are included, CHC care costs $65 less per person than for the population as a whole (4). And that figure does not even account for the greater costs for providing health care exclusively to the poor!

Despite the built-in structural conflicts, CHCs have succeeded in demonstrating that high quality, accessible health services can be provided for and actually improve the health of the poor, while functioning as a center for community economic development (9). However, the CHCs remain an anomaly and innovation which has not entered or been supported by the medical mainstream. Still marginal because reimbursement fails to support preventive and primary care, the CHCs are vulnerable to the political winds, currently blowing against community control and toward teaching hospitals. CHCs may soon resemble the limited, traditional medical model for which they were to have been the antidote.

At the same time the medical empires and academic health centers have gone "where the money is," offering to solve the problems of specialty and geographic maldistribution which they were responsible for creating. Federal policy-makers must reckon with this contradiction—in an era of cost-containment their support of hospital-based ambulatory care will increase direct costs, while generating indirect costs of

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Table 2

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<th>Bureau of Community Health Services</th>
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<tr>
<td>Primary Care, 1974 - 1979</td>
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<td>1974    1979</td>
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<tr>
<td>Administrative Improvements</td>
</tr>
<tr>
<td>Provider Productivity 3,072 4,015</td>
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<tr>
<td>Administrative Costs as Percent of Total</td>
</tr>
<tr>
<td>Ambulatory Costs 25% 22%</td>
</tr>
<tr>
<td>3rd Party Reimbursements as Percent of Total</td>
</tr>
<tr>
<td>Operating Costs 17% 38%</td>
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<td>Cost per Encounter $44 $32</td>
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*1975 Data

Source: Bureau of Community Health Services Data
One of the major successes of community health centers has been their documented reduction in hospital days for the populations they serve. Hospitals which are dependent upon high occupancy rates for their financial well-being won't like this decreased innovation, flexibility, appropriateness, community responsiveness, and personal service. Framing Sutton's law is another law, which states that while little thieves—like Willie Sutton—are penalized, the corporations prosper: caveat emptor. And we pay for both.

—Hal Strelnick

References

Books Received


Elison, Jack and Athalia E. Siegmann (Eds.) Socio-Medical Health Indicators (Farmingdale, N.Y.: Baywood, 1979).


within such rural and urban "health systems."

If the original neighborhood health center model is now reviewed, it is clear that several of its central elements are peripheral to the current thrust of federal policy. Reforms embodied in the neighborhood health center model included the provision of health services rather than medical treatment, the care of individuals within their own community, and the employment of new types of health workers. The biases in the Medicare and Medicaid system and the shift in BCHS policy to the support of large numbers of small scale programs has made it increasingly difficult for existing community health center programs to provide comprehensive health services and employ nontraditional health workers.

Another major innovation which was part of the NHC model was consumer participation in decisions about the provision of health services. That element of the original model was expanded when the Health Revenue Sharing and Health Services Act of 1975 mandated the establishment of Governing Boards to replace consumer advisory boards at each health center. The Governing Board is the grantee of federal funds to the center, establishes general policies for the center's operation, approves its budget and appoints its Administrative Director. The majority of the Board's membership is mandated to be patients enrolled at the health center (22). Recent legislative events suggest that this aspect of the neighborhood health center model is also threatened.

One provision of the latest legislation authorizing community health centers, the Health Services and Centers Amendments of 1978 (P.L. 95-626), establishes another new type of community health center program, a "hospital-affiliated primary care center." This is essentially a primary care group practice based in a hospital. Primary care centers do not have to have Governing Boards, but may instead create advisory boards (23). This legislation was introduced because hospitals which wished to apply for community health center grants felt that they could and/or would not meet the Governing Board requirements (24). Although only ten such centers were funded in FY 1980 (25), this program may signal the beginning of the "community-based, element of the neighborhood health center model.

—Alice Sardell

(Alice Sardell teaches health policy and urban politics in the Department of Urban Studies at Queens College/CUNY.)

References

8. Interview data.
10. Interview, Silver Spring, Maryland, July 11, 1979.