

MEDICAL ORGANIZATION, MEDICAL CARE AND LOWER INCOME GROUPS*†

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Abstract—This paper is addressed to an important policy question, very much at the center of American attention: how can high quality of medical care be achieved for all our population? Although my analyses and recommendations are directed at the local scene, I believe they are pertinent—with qualifications which will be touched on in my closing pages—to many another country. The chief reason is that although medical organization throughout the world varies widely in the scope of population covered and in how populations are serviced, the assumptions about medical care are relatively standard—and often they are built without scrutiny into the very fabric of a nation's system of medical care.

About my own country, I question in this paper whether its citizens can realistically expect anything like high quality of care without considerably more far-reaching reforms in our present system of medical and health care than are instituted by present legislation, or assumed in current planning. (And I have chosen deliberately not to discuss another important issue—whether *equality* of care can even be approached without radical changes in American social structure.) My argument, briefly summarized, is as follows:

(1) The national commitment to quality medical care for all citizens has led to important legislation, now having its impact at local levels. The emphasis is on extending and improving a basically sound system of medical organization so that medical care can be offered faster, more effectively, more efficiently, and to all sectors of our population.

(2) Behind this emphasis on delivering improved care is the assumption that hitherto medically disadvantaged groups—notably the lower economic groups—can be reached without radical transformation of the system of medical care.

(3) This assumption is dubious. If so, then major reforms in medical organization are required, otherwise the current great inequities in the distribution of medical care will continue.

(4) The medical system has never adequately serviced lower income groups in the past, because it was not designed to do so. Lower income styles of life are sufficiently different so that they must specifically be taken into account in organising medical care for these sectors of the population. Professionals have not been trained, and generally are not now being trained, in the special skills necessary to deliver quality care to these people.

(5) The recommendations that I give are based on the *necessity for breaking a vicious cycle* which characterizes the medical care of lower income patients. First, we must speed up the initial visit of the patient for medical care. Second, we must improve the experiences which he has in the medical facilities. Third, we must improve the communication, given and received, about necessary regimens. Fourth, we must increase the likelihood that the patient will properly carry out his regimen at home. Fifth, we must increase the likelihood of necessary revisits to the medical facility. And sixth, we must decrease the time between the necessary revisits. (Since this vicious cycle also operates, although to a lesser extent, with higher income patients, my recommendations are directed at improving care for those patients also.)

*This paper was commissioned by the Institute for Policy Studies, Washington, D.C., under the co-directorship of Richard Barnett and Mark Raskin. My thanks for useful consultation to Eliot Freidson, Melvin Sabshin and Lee Rainwater.

†(It had been hoped to follow this important material with a critique from a British author. Regrettably this has proved impossible within the time available.—Ed.).

(6) I suggest a number of recommendations, each directed at breaking some phase of the vicious cycle and deriving from considerations of the life-styles of lower income Americans. These recommendations do not necessarily require additional resources or finances; but a rearrangement of tasks and organization, invention of new organizational mechanisms, and the reallocation of expenditures. By no means are all the recommendations which I suggest original: what makes these recommendations different is that they are related to each other through the guiding idea of a "vicious cycle".

(7) To insure sufficiently broad action really to break this cycle, I argue one further recommendation. We need responsibility at four levels: professional, institutional, lay and governmental. Professional societies and schools must take responsibility for certain reforms bearing on the total restraining cycle. Medical facilities also need to consider how broadly across the cycle they can act. I argue that we need also to enlist the responsible efforts of lower income people; and further, that governmental responsibility for inducing needed reforms—as outlined in this paper—is also requisite.

In general, then, I argue that the national commitment to high quality of medical care necessitates reforms far beyond those usually envisioned in current planning and legislation. These reforms can be joined with the more usual, and certainly very necessary, recommendations for increased expenditure and manpower in order to improve medical care across the board [1].

INTRODUCTION

The national commitment

IN A SPECIAL message to Congress on January 7, 1965, President Johnson dramatically reaffirmed the nation's commitment to good health for *all* American citizens [2]. Quoting Jefferson's remark that "without health there is no happiness," President Johnson emphasized that "it is imperative that we give first attention to our opportunities—and our obligations—for advancing the nation's health".

Equally notable in President Johnson's reaffirmation of the nation's responsibility for the health of all its citizens was his explicit commentary upon the health needs of the poor. The problem of poor families rests not only on their lack of money—"Poor families," the President noted:

"increasingly are forced to turn to overcrowded hospital emergency rooms and to overburdened city clinics as their only resource to meet their routine health needs."

President Johnson's message prefaced what was to be sweeping and precedent-breaking medical legislation. After many years of national and congressional debate—and massive professional and political opposition—"Medicare" was passed. Legislation for establishing centers for Heart, Stroke and Cancer also was quickly passed. The latter legislation was designed to speed up the application of medical innovation, but also to give the leading medical schools, teaching hospitals and major medical centers a greater influence in leading the scattered medical community out of the essentially disconnected sprawl which the rural-oriented Hill-Burton hospital construction program had helped to further. Medicare represents an increasing emphasis on the hospital as the center and coordinator of medical care, and promises to lift the poorest of our aged out of the medical ghetto of charity care into the stream of voluntary and proprietary hospital care. In addition, the considerable national focus on poverty, and on the need for central city reform, and such programs as Head Start, all underline the national commitment to extend quality medical care to the most economically disadvantaged Americans. Indeed, in Johnson's 1967 budget message to Congress, he proposed a quadrupling of federal spending on health care and medical assistance for the poor in 1968.

INCOME DIFFERENTIALS AND MEDICAL CARE

Current inequities in the distribution of medical care and services have been well documented by the U.S. Department of Health, Education and Welfare in a study titled, *Medical Care, Health Status and Family Income* [3]. Statistics on personal health expenditures, health insurance coverage, the use of medical and dental services, chronic illness and disability, acute illness, and disability days, all demonstrate how greatly disadvantaged are the lower income groups [4]. For instance, the percentage of persons with hospital or surgical insurance coverage "is closely related to family income ranging from 34 per cent among those in families of less than \$2000 income to almost 50 per cent for persons in families of \$7000 or more annual income". At the same time, lower income families are more likely to have "multiple hospital episodes" than higher income families. The differential in health insurance coverage shows up strikingly insofar as:

"Among persons who were hospitalized, insurance paid for some part of the bill for about 40 per cent of patients with less than \$2000 family income, 60 per cent of patients with \$2000-\$3999 family income, and 80 per cent of patients with higher incomes. Insurance paid three-fourths or more of the bill for approximately 27 per cent, 44 per cent, and 61 per cent of these respective income groups. Preliminary data from the current survey year show, for the proportion of bills for surgery or delivery paid by insurance, an even more marked association with income."

Concerning the utilization of physicians' visits, the "pattern of utilization . . . is quite clear cut, showing an increase of visits . . . with increase in family income". Taking the extremes in family income groups (under \$2000 and \$7000 and over), the utilization patterns are not only clear-cut but strikingly different. Thus, the ratio of annual physicians' visits per person are 2.8 and 3.8. (For children under fifteen years of age, the ration is 1.6 to 5.7.) The differential use of medical facilities for physicians' visits is also indicated by the ratios for visits to hospital clinic respectively, 0.7 annual visits to 0.3. The tremendous advantage of the higher income groups in utilization of medical specialists is indicated by respective figures of 12.9 per cent and 27.5 per cent. (The income group between \$2000 and \$3999 is not much better off: the percentage who visit specialists is 13.9).

Concerning health expenditures themselves, this government survey showed that at each family income level, amounts spent for doctors' services comprised about a third of the total health expenditures (although the lower economic groups visit physicians less often). The highest income group averaged health expenses per person of \$153, whereas all other income groups averaged as much as, respectively, \$112, \$116 and \$119 per person annually. In other words, those who could least afford the health expenses paid annually almost as much as people who could afford most. Also, since family size tends to increase with lower family income, another health differential is not surprising: health expenses (\$104) for a child living in a three-member family with an income of \$7000 and over were five times greater than the amount spent for health care of a child in a family with seven or more members and an income of less than \$2000.

The lower income groups are strikingly disadvantaged in two other important ways. The first pertains to the amount of chronic illness and disability, the second pertains to the actual loss of working days due to disability. Among the lowest income group, 57.6 per cent have one or more chronic conditions compared with 42.9 of the highest income group. The figures for respective chronic limitation of activity from those diseases are 29 per cent and 8 per cent. Also inability to move about freely is clearly associated with family income: the figures are respectively 7 per cent and 1 per cent. And the percentage of persons with more than one chronic condition causing limitation is 59.8 per cent compared with 24.1

per cent. When these figures are translated into loss of work days, the burden falls heavily on the lower income groups: the respective figures for men are 10.2 days and 4.9 days; for women, 7.5 days and 6.5 days. The government report notes that even with respect to acute diseases among persons 45 years and older the incidence rates (as well as the rates for medically attended, activity-restricting or bed-disabling conditions) are higher for families with incomes of less than \$2000 than for any other income group.

Needed: a radical re-organization of medical services

It is patent that the lower income groups do not receive a fair share of the available health services. In the following pages, I shall show that lower income groups are disadvantaged in the medical market, not only because of fewer financial supports and less availability of services, but because of a drastic mismatch between medical organization and lower income life-styles. I shall argue that the *extension of quality care to lower income groups requires a radical re-organization of medical organization.*

In the lively public discussion and debate over the improvement of medical care and services, it is striking how little attention is paid to the mismatch of medical organization and lower income life-styles. Primarily the emphasis is placed upon how the present medical organization needs to be added to, or somewhat altered, so as *better to deliver* quality care to people who do not now get it. For instance, at the 1965 Health Conference of the New York Academy of Medicine various experts addressed themselves to the question of current and future medical organization and care. Although disagreeing on particulars, they constantly emphasized the necessity for improved outreach of medical services. Over and over, they focused on better delivery of quality care through increased facilities and manpower, or through more efficient institutional arrangements of current facilities and manpower. Thus, Dr. Robert Felix [5] (formerly of NIH, and currently Dean of the School of Medicine at St. Louis University) emphasized that now:

“When facilities have become available, with new knowledge accumulating, with more professionals available to deliver services, there remains *one barrier to full opportunity for achieving the right of health.* This is *adequate financing* of health programs.” (Our italics.)

Dr. Felix then remarked on the increasing responsibility by the Federal Government in the health services, predicting

- (1) Increased health insurance coverage to the point where no person need defer seeking medical attention because of finances.
- (2) An increase in ambulatory-type services.
- (3) Development of comprehensive regional or district health complexes [5].

The programs and planning of federal agencies are similarly sharply focused upon more financing and more resources and better delivery. For instance, the Children's Bureau programs are among the most advanced federal programs. In a 1963 paper, Arthur J. Lesser [6], Director of the Division of Health Services, Children's Bureau, remarked that a President's Panel:

“urged that a new program be established with federal funds authorized on a project basis to assist State and local health departments in meeting the costs of administering programs of comprehensive maternity and infant care for women who have problems associated with pregnancy . . . and who are unlikely to receive the care they need because of low income or for other reasons. These programs would make it possible to:

- (1) Increase the number of prenatal and postnatal clinics.
- (2) Bring the prenatal and postpartum clinics close to the population served.

- (3) Establish special clinics for some patients with complications of pregnancy (where more time by obstetricians, nurses, social workers, nutritioners and others can be provided.)
- (4) Pay for hospital care not only for the delivery but also during the prenatal period as needed.
- (5) Relieve overcrowding in tax-supported hospitals by paying for care in voluntary hospitals.
- (6) Pay for hospital care of premature infants and other infants needing special attention.
- (7) Provide consultation services."

Such recommendations have already become part of federal legislation. What is notable about the recommendations—which are altogether admirable—is, again, the emphasis upon additional financing, manpower and resources. (There was also some emphasis upon education.) But the special obstacles offered by discrepancies between medical organization and lower income life-styles are *not* frontally attacked.

What this signifies is that *current planning is based on a set of quite deficient assumptions*. *First*, it is assumed that there is basically nothing wrong with the organization of medical care, except that organization is not extensive enough to reach everyone adequately. *Second*, it is assumed what is needed for extending the health enterprise is more financial support, more manpower, more resources of various kinds (hospitals, centers, equipment, training centers.) Different planners and planning agencies give different priorities to financing, manpower, or resources, but all seem to think principally in such terms. *Third*, such re-organization of medical care as is called for—other than adding money, resources or manpower to the system—is principally in terms of improved efficiency of the medical care system. For example, a more extensive and well-wrought linkage of facilities and manpower, as in the "Heart, Stroke and Cancer" legislation. Or, a linkage of municipal and teaching hospitals, as in the New York City plan initiated by Trussel. I have no quarrel with much of the planning based on these assumptions. More money, resources, and manpower certainly will help distribute quality care more widely. So will some measures designed to improve the efficiency of present medical organization.

I contend, however, that *no amount of adding to, or tinkering with, the present system of medical organization is going to achieve medical quality or equity for all citizens*. Given the conditions outlined in the following pages, it will be difficult to maintain that a startling residue of inequity would not persist—despite all attempts to improve the delivery of medical services through measures currently suggested by medical planners. It is true that if all Americans had sufficient finances to pay for their medical care, and if the medical facilities were located so efficiently as to be equally accessible to all, and if each medical facility were manned and equipped with great efficiency, then the medical care offered Americans certainly would be greatly improved. But there would still remain a striking discrepancy between the care received by lower and higher income groups—due to exactly those factors that will be outlined below.

There are no ready means whereby my contention can be proven. (The assumptions underlying current planning cannot be proven either.) Nevertheless, we do know that when medical facilities are set up in convenient proximity to lower income housing, they do not automatically draw clientele. In one instance, a clinic located between a lower income and lower-middle income population was almost wholly used by the latter. Other clinics located in lower income areas frequently follow a typical cycle: at first the staff is enthusiastic, and its enthusiasm is conveyed to its clientele; but as the difficulties of making much of a dent on lower income illness begin to wear down the staff, enthusiasm decreases, there is turnover of personnel, and eventually the clinic is much less effective in drawing or keeping its patients. No doubt medical facilities located nearer the homes of lower income people are

more likely to draw and keep patients, but their mere presence does not solve the problem of delivering effective care to most people in the nearby locale.

If the national commitment is to be met in earnest, it is necessary to re-examine certain features of health services not ordinarily discussed in the context of America's strikingly large health gap. These features include certain dominant perspectives of the health professionals, their types of training, and the ways that medical facilities, especially hospitals, are organized. Facilities and personnel need to be seen in conjunction with certain widespread characteristics of lower socio-economic life, including: dominant styles of living, attitudes toward health, and typical experiences with health services.

In general, I shall emphasize that professional perspectives and training, and the organization of facilities are not conducive to offering quality medical care to the lower socio-economic groups. Medical training and organization evolved principally to service a clientele that could afford to pay for medical services. Those services were extended traditionally of course (in a kind of double-truck system) through municipal hospitals, out-patient clinics, and some private practices. Medical organization and attitudes, nevertheless, were (and are) less suited to the life styles of the lower income groups than those of higher income [8].

If this is so, what re-organization of the medical and health services will be necessary in order to give quality care to these Americans also—without destroying the quality of care now available to more fortunate segments of our population? A parallel question which will be explored is this: What will happen if the nation fails to institute an efficient re-organization of medical care? In general, my answers will be that if we do not institute re-organization of medical care, then its distribution will continue to be exceedingly inequitable [9].

THE ORGANIZATION OF MEDICAL CARE

There are two major factors—relative to medical organization—that contribute to inequities in medical care. The first consists of the current organization of medical services. This acts as a brake on giving quality care to lower income groups. The second consists of the life styles of the lower income groups, which unquestionably constitute an obstacle to their receiving quality medical care.

Negative features of medical organization

Even when medical services are readily available to lower income groups, these services are characteristically under-utilized. In some part this under-utilization is caused by some characteristic features of medical organization itself. And these same features of medical organization tend to blunt the effectiveness of medical care when patients of lower income status are actually in treatment.

What are these inimical characteristics of medical organization? *First, there is the very massiveness of medical organization itself.* Hospitals and clinics are often large, the division of labor rather complex, the work of diagnosis and treatment involving elaborate coordination of specialized hospital services and of staff effort. As Rosenblatt and Suchman [10] remark in their study of the under-utilization of medical services in New York City, medical care requires specialization of function and specialized clinics, the whole enterprise being marked by a fair degree of impersonality. Even middle class patients feel this impersonality, for it is one of their chief complaints about hospital care. But lower income people are less well equipped by education and experience to understand elaborate organization, or to cope with it [11].

Why this is so is clear enough. Their own organizational life is meagre, unlike the more typical experience of people of higher economic and educational status. As we suggest later in more detail, the life of lower income people tends to be rooted in narrow locale and in family, and is less in contact with a wider community life. They do not belong much to voluntary organizations, whether economic, political or social. They may have jobs in large organizations, but they do not run those organizations and play little part in managing organizational activities even at the lowest levels. Indeed they have not usually much grasp of organizational operations. We need not at all attribute deficiencies of intelligence to lower income people to explain why they have difficulties in understanding and coping with organization, especially when it is complex: we need only remember their lacks in education and in experience.

When a lower income person enters a clinic or hospital, he is confronted by problems of understanding how it works, what it expects of him, and how best to get around in it. These institutions are organized for getting work done, whether it be diagnosis, treatment or "comfort care". They are only infrequently set up to minimize the patient's potential confusion except in certain matters, such as those pertaining to admission, or "where to go to get examined" or to wait for examination, or which clinic is the appropriate one to attend. Otherwise the patient must figure things out for himself, except insofar as he can get someone else to explain matters he wishes or needs to know. It is not unknown for lower income patients literally to get lost when sent "just down the corridor" in what seems an incredibly big, confusing institutional world. The directions given them seem inadequate, the manner brusque. A typical situation in emergency rooms of municipal hospitals is that patients sit for many minutes, even hours, expecting to be examined by order of appearance; but they are puzzled and angered because patients who come in later are taken "out of turn". They do not understand, and the staff does not bother to explain, that there are different kinds of emergencies and therefore different priorities of medical actions.

These examples represent rather simple levels of misunderstanding or of confusion or frustration, but countless more subtle ones can be cited. For instance, hospitalized patients are often sent for diagnostic tests from one hospital service to another, with little or no explanation of what the procedures are all about. Patients can be rendered exceedingly anxious by this whole process. Their anxiety may be relevant to the diagnosis itself if it affects the diagnostic findings without staff's awareness. Another instance of how complex organization baffles and frustrates the patient who does not easily find his way within it is the frequent complaint of patients, in medical plans such as Kaiser's, that they cannot find a clinic doctor whom they really like or trust. Yet the more knowledgeable, and typically the more "middle class" patients quickly discover how to "beat the system" so as to find a trustworthy doctor and to ensure assignment to him whenever they visit the clinic. The total impact of such experiences on lower income patients is considerable. Whereas higher income patients may be angered but understand (at least somewhat) what is happening at the clinic or hospital, the lower income patients understand less what is happening regardless of their consequent reactions. It is worth emphasizing that lower income patients are much less likely to have private physicians than are the higher income patients. Therefore, they have no agent who can explain the behavior of a hospital staff to them, or who can manage the establishment so as to get seemingly important things from it.

A second feature of medical organization decreasing the quality of care they might receive is the professionalization of health workers. Training in specialized schools (medicine, nursing,

social work) results in characteristic goals, perspectives toward work, and modes of working with machinery and men (including patients). The higher the level of specialized knowledge attained by the professionals, the more the clients who utilize his services must take his abilities and knowledge on trust: for the gap between their understanding of these specialized matters and his is great. Some procedures insisted on by professionals may seem senseless or even dangerous, and the professionals' manner of issuing directives—or of avoiding issues—may seem impersonal or even brutal. Yet the professionals are carrying out those actions, for the most part, with genuine concern for the patient's welfare.

Again the lower income patients and their families are at some disadvantage as compared with higher income people. Generally, the former are less able to comprehend the various professional stances and their implications. They may be quite unable to understand the nature of the prescribed treatment. They have less understanding of basic psychological processes and so understand less of the diagnoses. They are less able to sense when a professional judgment may be wrong, if only because they understand less of the medical language and the specialized perspective. Physicians may assume too much about the understanding of patients and fail to communicate the sense of treatment or a prescribed regimen. Or they may not attempt to explain much, reasoning that these patients' education is insufficient to allow real comprehension. Of course the physician may decide to withhold information for very good professional reasons. The result is that patients of all income groups typically complain a great deal about the difficulties of getting sufficient information from physicians and nurses. But lower income people are less skilled at engineering matters to get that information. They are less experienced in the tactics of forcing explanations or trapping staff members into explanations. They tend also to be less aggressive in demanding explanations. Fred Davis [12], in a study of polio patients and their families (mainly of lower income status), has described the situation very vividly:

"In general, the behavior of parents (is) . . . eager, deferential, and subordinate; that of hospital personnel, especially the doctors, as brusque, noncommittal, and superordinate, even at times—or so it seemed to parents—condescending or indifferent. Mrs. Short's account . . . reflects a typical experience: 'Well they don't tell you anything hardly. They don't seem to want to. I mean, you start asking questions and they say, 'Well, I only have about three minutes to talk to you.' And then the things that you ask, they don't seem to want to answer you. So I don't ask them anything anymore . . .'"

The greater aggressive and interactional skills of higher income patients yield a far better countering of strategies of withholding information, whatever the professional's reasons for withholding. In consequence, lower income patients and their families are frequently frustrated by an inability either to understand what is happening or to control events deemed important to themselves.

The greater interactional skills of higher income patients also allow them, on the whole, to manipulate the work of professionals—the pacing and scheduling of work, for instance—and this management may lead to their improved care. Just as these patients will complain more effectively about poor food, they complain about or negotiate for "baths later," for more frequent or powerful medication, and the like. Lower income patients, as is generally recognized, tend to be more docile, less aggressive, in making such demands. When they make them, they tend also to be less effective in getting them answered. In addition, the lower income patient is less likely to make direct requests of his private physician. Since he is also less likely to have a private physician at all, he has less opportunity to call upon him to intervene with the hospital staff for correcting possible deficiencies of care [13].

There is a more subtle disadvantage, stemming from professional stances, which lower

income patients suffer. The treatments deemed useful may vary somewhat in accordance with the professional's view of his patient's socio-economic status. By this, we do not mean the expensiveness of drugs ordered or the number of days of treatment that the physician judges his patient can afford. Thus, concerning psychiatric treatment Frank Riessman and Sylvia Scribner [14] summarize that "middle class patients are preferred by most treatment agents, and are seen as more treatable. Psychotherapy is more frequently recommended as the treatment of choice, and diagnoses are more hopeful with symptomology held constant." In other words, there may be a distinct bias expressed against the lower income patient, based honestly on professional conceptions.

More usually, however, the professional makes the assumption that treatment and care should be determined by disease process. Consequently, physicians tend to prescribe the same treatments, the same regimens, for patients regardless of income status (except insofar as finances set limits). As we shall detail later, the lower income patient is thereby further disadvantaged for often the regimen is unsuited to his style of life, or the medication prescribed is so inadequately explained to him that he does not take it correctly, and so on. Riessman's [15] comment about psychotherapy for lower income patients is apposite, here:

"treatment as *presently organized* is not congenial to low-income clients, is not congruent with their traditions and expectations and is poorly understood by them. In essence, these clients are alienated from treatment."

But mental disease is not the only area about which such statements can be made: prescribing regimens for certain cardiac patients is done without adequate awareness of how impossible they may be for the patients to carry out. Even the simple order that medication is to be taken "with each meal" may run afoul of the fact that many lower income families eat irregularly and so do not have three meals a day.

A third characteristic feature of medical organization which profoundly influences the quality of medical care received by lower income patients—is the middle class bias of most professional health workers. Typically all but the lower echelons in hospitals and clinics are of higher socio-economic status than the lower income patients. This difference between staff and those patients results often in two striking disadvantages for the patients. One consequence of the staff members' social background is that they do not understand the perspectives, attitudes, customs and life styles of the patients; they take for granted that the patients are human like themselves! The patients have regular meals at home—just like us. Men conscientiously can support their families—just like us—or have steady employment or lead regular lives, or have the same protective attitudes toward their children, or have the same attitudes towards health as we do. Precisely because professionals make these assumptions about lower income people, they issue orders that are not understood or cannot easily be followed by the patients [16].

A much cruder aspect of the class differential is that many professionals display genuine prejudice against lower income patients, (sometimes side by side with the assumption that "they are just like us"). Like middle class people outside the hospital, they often think of lower income people in stereotyped terms. The latter are "like children", and must be treated as children. They cannot keep appointments, having little sense of time or responsibility. They are shiftless, irresponsible. They have children out of wedlock, They are dirty, unkempt, unclean. Sometimes these biased notions are expressed very openly by hospital personnel—notions and expressions probably both abetted by the tensions of a busy and often harried schedule of work. In any event, patients often comprehend or sense what the

staff thinks of them, and may either suffer through the prejudice or choose not to return to hospital or clinic. While some of their dislike of municipal hospitals and clinics is attributable to overcrowding and poor service, some dislike is unquestionably due to the class bias of the staff members. There is not much doubt that this kind of class bias, then, profoundly affects both the quality of medical care which these patients receive and their under-utilization of medical services.

A fourth feature of medical organization is that a great proportion of these patients (especially in urban areas) are serviced at municipal and county hospitals. These facilities typically share certain characteristics. Usually they are run on tight budgets, at lower costs per patient than most community or proprietary hospitals. They also service great numbers of patients. Consequently they tend to be relatively understaffed, especially by professionals. The nursing personnel tend to remain at these installations for many years, and consequently develop routine modes for handling and caring for patients. Often they tend not to be quickly receptive to newer ideas in nursing. Typically these facilities have few or no visiting staff physicians, but are administered by residents and internes. These men tend to be enthusiastic but are not yet very experienced in the nuances of medical care, and certainly not in human relations. Frequently the hospital is very large and may even be spread among many separate buildings [17].

These hospitals and their accompanying outpatient clinics are easily imagined by patients to be terribly massive and complex, crowded and busy; while the personnel seem often impersonal, brusque or even insulting. In fact, the places do tend to be massive and crowded, the staff very rushed with need for quick movement. The physicians go from patient to patient, spending brief moments with most, accompanied by a nurse. (And where the hospital is affiliated with a medical school, the busy—often disease oriented—physician is accompanied by an absorbed group of medical students, and by one or more residents or internes.) Patients get not much opportunity to ask questions of the busy physician or nurses. In the clinics, patients may sit for long periods of time waiting to be called, without being addressed, or paid attention to, by personnel moving to and fro. In the hospitals, the nurses are frequently busy with administrative tasks so that nursing assistants spend more time near and around patients. Patients see all of this, and may simply respond fatalistically to the rush and the bustle. They may also inaccurately attribute to the staff a humiliating brusqueness when none was meant, indifference when the personnel were only busily abstracted, and class or race prejudices where none was displayed [18]. Nevertheless, by their very characteristics these medical institutions maximize aspects of medical organization which are among the most inimical for providing quality care. Even when the staff is excellent, or the facility is connected with a top-flight medical school, many if not most characteristic features of these places still persist [19].

Medical organization and "Medical care"

There is another feature of medical organization worth special attention: its special focus on medical and procedural aspects of "care". A certain ambiguity attends the use of the term "medical care". It will be convenient here to discuss its relationship to medical organization by distinguishing grossly among "diagnosis", "treatment", and a third aspect which perhaps more properly deserves the name of "care" (whether nursing or medical). In common parlance, diagnosis means the detection of disease processes. Treatment means what is done about the disease process in order to arrest the disease, improve the symptoms, and so on. Medical services are superbly organized to carry out both diagnosis and treat-

ment—that is what the health professionals traditionally are trained to do, and what medical research has focused on. The virtual eradication of many acute diseases from the American population has rested upon their accurate diagnosis and effective treatment. Public health personnel, hospital personnel, and private practitioners have all shared in that success.

In general, medical organization is less successful in the diagnosis and treatment of lower income groups, in part because medical services are less available or accessible to these people, in part because generally they themselves are less concerned about health (a point we shall discuss later). Nevertheless, even for this segment of our population, the Achilles heel of medical organization is neither diagnosis nor treatment. *Its weakness lies principally in the vaguer residual area of "care", which includes much nursing care, various kinds of instructions to patients about their regimens, along with the general evaluation of—and communication about—progress or retrogression after patients leave the hospital.*

Let us focus only on post-hospital care. Whereas higher income patients can call upon private physicians for evaluations of progress, or are likely to visit their physicians if progress eventually is not apparent, the lower income patients are much less likely to have private physicians. For checkups they must return to busy out-patient clinics, where incidentally they rarely see the same doctor twice (except through union insurance plans or plans like HIP). For a short while or in emergencies, they may be attended occasionally at home by visiting nurses, or given procedural and health instructions by public health nurses. But most lower income patients are very much "on their own" after leaving the hospital or clinic. This is because hospital and community—as many critics for many years have noted—are relatively separate entities. Traditionally, most hospitals grew up either as servicing agencies for poverty stricken patients or as places where private physicians could house their patients. Hospitals are even rather insulated from public health agencies; they are certainly quite insulated from the homes of their ex-patients. So once again the organization of medical services (of hospital and clinics especially) tends to the disadvantage of the lower income patient. He gets less "continuity of care".

Under-utilization of medical services

Various research studies and surveys have reported medical services are under-utilized by lower income groups. For instance, the Director of the Division of Health Services, Children's Bureau, has noted "Large numbers of women are receiving little or no prenatal care." And:

"In Atlanta, 23% of women delivered at the Grady Hospital had had no prenatal care; in Dallas, approximately one-third of low-income patients receive no prenatal care; at the Los Angeles County Hospital in 1958, it was 20%; at the D.C. General Hospital in Washington, it is 45%; and in the Bedord Stuyvesant section of Brooklyn, New York, it is 41% with no or little prenatal care [20]."

Some under-utilization unquestionably is due to the attitudes and life styles of lower income people, which mitigate against more frequent use of medical services even when readily available. Dr. Frank McPhail [21], in a Dallas County Youth Study, reports that such things as "cultural difference," "working mothers," "finding somebody to stay with the other children," and "seeking care too late," are among the factors which are deterrents to good (prenatal) care. We shall have more to detail about the relevance of attitudes and life styles in the next pages.

But we should note that much in preceding pages is also pertinent to the under-utilization of medical services. Patients' real or imagined perceptions of class and race bias, their many

hours of waiting, the seeming or actual impersonal routines of institutional care, and the like, maximize the dissatisfactions of lower income patients—and further the possibility of infrequent visits or of no visits at all. In addition, patients may feel like “charity patients,” and we know from interviews that some patients are reluctant to go to such clinics and hospitals because they believe that “what is free is not much good.”

Also, the distances that patients must often travel to the medical facilities and the fares that they must pay to travel there, further the under-utilization of services by raising realistic questions of money and time. Some lower income people are so poor that even expenditures for carfare must be carefully calculated. In addition, if emergencies seem to demand the use of taxis, the money may not be available. The ecology of medical services can work to their disadvantage in a more general sense. These people customarily organize their lives so as not to go far for the necessities of living. They tend to shop close at hand for most things. They do not travel much about the city except to work or for the occasional visiting or entertainment. The women especially tend to stay close to their homes or neighborhoods and not infrequently are anxious about venturing farther afield.

Sometimes other obstacles to utilization derive from medical organization itself. Thus

“many patients are ineligible under too restrictive financial requirements and yet cannot afford to pay the rate many hospitals charge for ward patients . . . Some hospitals require that clinic patients have one or two pints of blood deposited in the blood bank upon admission to the clinic. Inability to meet this requirement . . . leads to the omission of prenatal care [22].

One set of authors who have studied under-utilization of services in New York City, concluded that genuinely to increase the utilization of services by “blue collar” people, “modern medicine . . . must adapt itself to new forms of social organization . . . some adjustment will have to be made so that the relative alienation of large segments of society will be corrected” [22]. The authors are quite correct in that judgment.

HEALTH AND THE LOWER INCOME GROUPS

We have asserted that contemporary medical organization is not well adapted to giving quality care to lower income people. Now, we suggest further that our *medical organization rests on several assumptions about “the patient” which constitute additional obstacles to giving quality care to lower income people.*

Assumptions about patients

The methods whereby health professionals give quality care assume a certain kind of patient, as well as the existence of certain relationships between the patient and the professionals. First and foremost, the patient is supposed to have his own self-interest at heart—so that when he suspects he is sick he will seek professional help, and when given a regimen to follow he will attempt earnestly to follow it. He must thereby be an active agent: he has to recognize when to visit the doctor, make decisions about which doctor to visit or when to abandon one doctor for another, control his fears and anxieties when in the hospital or clinic, and suppress actively his disposition not to follow the doctor’s “orders” in favor of doing as commanded. If necessary, he must organize his life so as to manage a medical regimen. He has also to take himself back to the physician when symptoms reappear or worsen. It follows that he must trust the health professionals and especially his physician; but if not, then he should seek out others whom he believes are trustworthy. In short,

medical organization tends to assume a rather educated, well motivated patient, who is interested in ensuring a reasonable level of bodily functioning and generally in preserving his own health.

Not all highly educated or personally well-financed patients fill these expectations. Yet it can safely be asserted that the higher income groups, on the average, are closer to this image of the ideal patient than are the lower income groups. In fact, health professionals often complain, or shrug their shoulders fatalistically, about how lower income patients fail on a number of counts: they come to the clinic or hospital with symptoms in advanced stages, or parents don't seem to pay any attention to children's symptoms until well advanced, they return with the same diseases when cured or temporarily arrested or with worse symptoms if told to follow given treatment, and whether from laziness or non-comprehension or environmental difficulty they often cannot follow even simple regimens; also, when they do return, they have often delayed too long. In some hospitals, the staff openly express derogatory attitudes when certain lower income patients appear month after month, especially if the fault can clearly be pinned on the patients.

It is unnecessary to assign blame to whole sectors of the population who tend not to match professional expectations! If professionals have not discovered the reasons—and built this discovery into their professional training—that is understandable also. I shall try to illuminate both issues, drawing upon rather well documented findings about the general tenor, and characteristics, of life among the lower income groups. I would underline the qualifying adjective “general,” since probably not every ethnic group (and certainly not every person) of lower income conforms to my description. But the general picture that will be drawn is relatively well founded, especially as it pertains to the *lowest* income group. But it is also relevant to many persons of the next highest income bracket.

The facts about these patients

The lower income person's experience of himself and his world is highly distinctive, in our country. It is distinctive for its qualities of concentration on the deadly earnest present. It is also distinctive for its problematic and crisis-dominated character. (As S. M. Miller has commented about these people, their “life is a crisis-life constantly trying to make do with string where rope is needed.”) This pervasive problematic character of life tends to make unreal the careful and solicitous attitude toward health held out by the health professions, and by and large subscribed to by the higher income groups. Such concerns often seem empty or minor to those who feel they confront much more pressing troubles. They will often be inclined to slight physical difficulties in attending to more immediate ones, such as making ends meet during a particular day or week. Health problems are just one crisis among many that they must try to cope with, control, or just live with. The same medical problem is likely to stand out much more sharply for the higher income person, because his energies tend to be more quickly mobilized by anything threatening his health. Even for the so-called “stable working class” of Americans, who perhaps do not so frequently face the same chronic crisis situations, life often is made up of a series of difficulties just barely coped with. Many live with a continual sense that the world holds many potentialities for pushing them down into an unstable, crisis, kind of existence.

Another very general characteristic of lower income life—especially the lowest income group—is that the households often are much more understaffed than those of higher income. The complement of family members who normally maintain and manage a household, including at least a husband and wife, is much more often absent. Thus under-staffing

of households means that each individual's health receives relatively little attention as far as preventive measures are concerned, and when someone is sick then it is more difficult to care for him at home; and when the main family member is sick he or she will be in a disadvantaged position in caring properly for himself or herself, or in finding time to seek medical aid. The family's attitude toward even chronic illness is apt to be fairly tolerant: people learn to live with illness, rather than using their small stock of financial and psychological resources to do something about illness.

As for the human body itself: whereas higher income people tend to think instrumentally about its ailments, believing that improvement is generally possible, lower income people seem more inclined to accept ailments fatalistically or as natural to living and aging. They are likely to accept impaired bodily functioning as inevitable earlier in life. Rosenblatt and Suchman [27] have noted about "blue collar" Americans that:

The body can be seen as simply another class of objects to be worked out but not repaired. Thus, teeth are left without dental care, and later there is often small interest in dentures, whether free or not. In any event, false teeth may be little used. Corrective eye examinations, even for those people who wear glasses, is often neglected, regardless of clinic facilities. It is as though the white-collar class thinks of the body as a machine to be preserved and kept in perfect functioning condition, whether through prosthetic devices, rehabilitation, cosmetics, surgery, or perpetual treatment, whereas blue-collar groups think of the body as having a limited span of utility: to be enjoyed in youth and then to suffer with and to endure stoically with age and decrepitude.

Some students have suggested lower income people are characterized by relatively low esteem. Hence, the authors of the preceding statement add that "it may be more that a more damaged self-image makes more acceptable a more damaged physical adjustment." Another researcher, Lee Rainwater [24], remarks that these people, especially the lowest income group, develop

"a sense of being unworthy, they do not uphold the sacredness of their persons in the same way that middle class people do. Their tendency to think of themselves as of little account . . . readily generalized to their bodies. In any event, fatalism about bodily functioning is certainly characteristic of lower income people as they move toward middle age."

Their attitude toward the body applies by extension to the bodies of children. Parents display greater tolerance for physical disability or malfunctioning in their children than do higher income parents; sometimes being seemingly indifferent even to obvious infections, sores and colds. This acceptance of something short of good health has implications both for the care of children already ill and for preventative regimen.

The next question is when do they tend to seek medical treatment? The answer is: only when the impairment of bodily function becomes so obvious, or great, that medical action seems needed. The pressing problems of daily existence tend to minimize the problem of illness so that

"symptoms which do not incapacitate are often ignored. For the white collar groups, illness will also relate to conditions which do not incapacitate but simply by their existence call forth medical attention [25]."

Another relevant consideration is that health education is much less advanced among these income groups than among people of higher income. Since illness is not usually self-evident except in late stages, health education is of considerable importance in recognizing illness. Particularly is this so for relatively mild or episodic chronic disorders that do

not fully incapacitate or do so only temporarily. It is even more true of diseases with mild symptoms that appear to go away after a period of time.

Once illness is perceived and once it is believed that something should be done about it, these people are less inclined to use specifically medical institutions that are for higher income people. They are inclined to treat themselves with folk medicine or patent medicine. And they are likely to seek out health advisors not only from kin and acquaintances (as do also the higher income people), but also the neighborhood pharmacist, the chiropractor, and, on occasion, folk-practitioners—like the *curenderos* among Spanish-speaking people or the sellers of charms in Negro ghettos. These advisors or healers are not only less expensive than physicians, they are less foreign and psychologically remote. To the client, they seem more like himself than those who work in medical institutions—even if their advice or care is not free [26].

Whether the lower income person seeks medical relief from a physician or someone else, “he is more likely at an advanced stage of illness than his higher income counterpart” [27]. (The government figures quoted earlier reflect this.) He is also more likely to be in a perceived or actual state of emergency. And whereas the higher income person probably will visit a private physician before any necessary hospitalization, the lower income person is considerably less likely to visit one and less likely to be referred by him to a clinic or a hospital. A very usual path is initially to visit a clinic or emergency room, and then be transferred into the associated hospital. (Sometimes the private physicians whom they visit initially are themselves so insulated from the medical care system that they do not have hospital connections, although perhaps they are able to refer patients to physicians who do. Sometimes these patients are referred to clinics and hospitals by welfare agencies.) Hence, the lower income patient is apt to enter a hospital quite unsupported by any neighborhood representative.

The difficulties of lower income people in clinics and hospitals are compounded by how they tend to behave in medical settings. As we suggested earlier, their behavior is often frustrating and annoying to medical and nursing personnel, for they frequently violate expectations about how “good” and “considerate” patients should behave. Lack of punctuality in keeping appointments, and walk-in and emergency demands, irritate the personnel because their own time is carefully measured and allocated. Other matters, including personal hygiene, also irritate the staff: these patients may not wash before visiting the clinic or hospital, may not cover their mouths when told to cough. Furthermore, they are not so likely to give excellent medical histories to examining physicians; they tend not to have very precise notions about time, do not discriminate experience by conventional disease labels, and very often have very unconventional notions of anatomy and bio-physical systems.

A point especially worth emphasizing is that they do not respond well to a properly professional “impersonality” but seek personal relationships, rather than professional ones, with staff. This search is consonant with their behavior outside of medical settings, for they tend to personalize most relationships. They are, in fact, generally not familiar with, or are uncomfortable when in unaccustomed contact with, large institutional complexes. In clinic and hospitals, these patients are confronted by an elaborate division of labor. But they are accustomed to dealing with people in non-segmentalized ways. So these patients are even more likely to be confused and frustrated by the hospital’s many functionaries than are the higher income patients. Since the former have fewer opportunities to request their own physician to sort out difficulties in the medical setting, or to moderate its impersonal division of labor, they are prone to a sense of pervasive anxiety when in these settings—and

especially perhaps in hospitals. This pervasive anxiety is well depicted in a study of obstetric patients by Rosengren [28]. Contrasting "blue-collar" with "middle-class" mothers, he remarks:

"Consider the blue-collar woman: the relative personal and social isolation in which she lives . . . and the life milieu in which she lives, where illness, incapacitation, and the like abound; and also the very real, heightened chances that either she or her baby may encounter either insult or accident during pregnancy—all of these . . . combine to make the-pattern of high sick-role expectations . . . particularly understandable. Considering also that the blue-collar woman is likely to be cared for in a clinic setting rather than by a private doctor it is easy to see why she might regard herself as "ill." The middle-class woman chooses her own physician . . . She appears for her prenatal care in a treatment setting which has little of the symbolism of sickness . . . in dramatic contrast to the clinic-attending woman who experiences her treatment within the confines of a hospital with . . . nurses and internes scurrying about, sometimes in apparent anxiety, with stainless steel, tile walls, and medicinal odors intermixed with medical machinery and equipment."

Abetting the patient's anxiety is a feeling of isolation, sometimes furthered by the realistic difficulties facing family members when they attempt to make frequent visits. Also family ties may be so weak that relatives do not bother to visit often.

In these medical settings, the lower income patient is markedly subordinate in his relations with virtually all staff personnel. This tends to result in a blend of passive submissiveness and hostile evasiveness in his relations with them. As we noted earlier, derogation and hostility is often expressed by staff members, both covertly and overtly; so the patient's typical response is hostile withdrawal from the staff members, allied with resentful docility to their "orders," prescriptions and suggestions. The socio-cultural subordination of the lower income patient is emphasized by his economic subordination. Often he is receiving free treatment, and so is required to be grateful, subject to the convenience and requirements of those giving services rather than able to insist on his own perceived needs. What is given to him in many hospitals and what he may choose is largely a function of routine administrative determination—with corresponding limitations on his own powers of negotiation. This is true even when he is a paying patient, for generally he has had less experience than the higher income patient in maneuvering within organisational structures. This inability is sometimes compounded by excessive shyness in such situations, especially by the women, by rather little verbal agility, and in the case of recent immigrants by not being able to handle English well. Repeated visits to clinics or hospitals may give them more skill in negotiating with staff members—but many are so frustrated by the first visits that they do not return.

To suggest that this picture is not in the least overdrawn, we offer a true case. A laborer, who had health insurance through his union brought his ailing wife to the clinic. She was transferred to the associated hospital, operated on for a tumor, and then sent home. Her husband was told nothing about the tumor, only that his wife "would be all right in a few days". Back home in bed, his wife dripped urine continually—as she had before hospitalization—and so after "a few days" the husband complained to the surgeon, but without getting his point across. After several more days, and further complaints, he went to a neighborhood physician with his problem, but without any success. He then approached the union's social worker, but she did not really understand his problem and so she made inquiries of the hospital but did not manage to solve it. Then he gave up going "for help," but by accident a nursing student who was making a study of "difficult cases" was directed to this family by the union's social worker. The student discovered that the family's big concern was the constant urinary drip. The nursing student intervened, requested a urinary plug via the social worker, thus solving the essential medical care problem as this family saw it.

In hospitals or on hospital services devoted to the care of permanently chronic patients, one can see written large the difficulties of lower income patients. For instance, Julius Roth, in a careful study of a rehabilitation unit within one New York City municipal hospital, has shown how the staff, imbued with professional ideals, gets discouraged with attempting to rehabilitate their virtually unrehabilitable chronic patients. (They are "un-rehabilitable" if only because they have few or no resources to maintain themselves outside the hospital.) The staff members adapt to this situation by understandably concentrating effort on very few patients. In consequence, the remainder are unlikely ever to leave the hospital except to enter another custodial institution, unless they have interested families who will receive them back however disabled. Regarding the patient's possibilities for negotiating either for treatment or eventual discharge, Roth observes that:

"For a patient to survive with any possibility of independent action in such a situation, he must either be able to aggressively and skilfully coordinate his own program and fight for action on many aspects of that program, or he must have an independent agent working on his behalf—an agent—independent of the entire institutional system . . . A few patients are able to act fairly effectively as their own agents. A few others have family members or other outsiders who are more or less willing and able to carry out part of this goal—especially offering an escape by providing a place to live. The majority . . . must accept whatever disposition is offered . . . for example, accept a foster home placement just to get out of the hospital . . . In most cases, they are simply stuck in some part of the hospital with no way of getting out [29]."

In its turn, the professional staff either suffers from rapid turnover or its members retreat into "enclaves of research, administration, and teaching."

The gap between assumptions and facts

In this section of our report we have depicted the great gap between important assumptions made about lower income patients by professional staff and the realities of lower income life, attitude and behavior. While the picture of those realities may be somewhat overdrawn, being more accurate the further down the income ladder one looks, most researchers who have studied the lower income groups agree about the substantial accuracy of the picture. Yet this knowledge has not been adequately built into the training of health professionals, nor has it especially affected the organization of medical care in hospitals or clinics (or health care outside of those institutions).

IMPLICATIONS OF INCREASED MEDICAL CONSUMPTION

Four trends and their consequences

If this contention is correct, then the future of medical care appears gloomy indeed. There are additional reasons for pessimism. Chief among them is the steadily increasing flow of new purchasers of medical services, including a considerable ratio in lower income brackets. The latter will add to the already tremendous strain on the resources of municipal and county medical facilities. In a study of New York City hospitals, NORA PIRELLI has estimated that municipal hospitals now service more than half of the city's families. And in "a broad sense, aggregate tax expenditures for personal health can be said to furnish low-income families with a counterpart or substitute for the institutional services purchased through voluntary health insurance by the better off members of the population." She points out that although 72 per cent of the city's population has some form of health insurance, "nevertheless the pressure on the city hospital-care system has in no way diminished [30]. Significantly, she also contends that whereas state and federal services are relatively inelastic, the city's obligations for medical care are quite open-ended. In short, this means

increased density of patient populations, increasingly discrepant ratios of professional staff to patients, and almost certainly further frustration for both. Of course, it means also a decreasing level of medical care. Between the pinch in resources and the varied political pressures, it is unlikely that much attention will be paid to any fundamental reform in medical organization itself. The emphasis will almost certainly again be on "resources," "manpower," "money" and an improved "delivery system" [31].

Another important trend that makes for some pessimism about quality care is the increasing number of lower income patients who will be entering community hospitals and clinics as paying patients. (In San Francisco, for example, recently there was a debate whether to close the municipal hospital or enlarge it, because of the anticipated influx of lower income consumers into the metropolitan medical market.) Not all patients, even the indigent, were ever given medical care solely at municipal or county hospitals. But the spread of health insurance—especially when purchased through unions or at place of work—means that increased numbers of employed men and their families in the second lowest income bracket will come to medical settings as paying patients. Hospital administrators of community hospitals have shown signs of some fright over the potential number of such patients, visualizing both strained resources and "problems" with these patients. One hospital administrator of our acquaintance said in committee that if the municipal hospital were abandoned, his own community hospital would have to build a separate wing because its regular patients would never tolerate the new type of patient. His outspoken reaction is symptomatic of how many hospital personnel will react to an increased flow of these new patients. Most relations described earlier between middle class professionals and lower income patients are very likely to be exacerbated [32]. The quality of medical care given all patients cannot help but be affected in some degree [33].

A third trend already affecting the quality of medical care given lower income patients is the continued development of such plans as Kaiser in California and HIP in New York. The plans have relied considerably upon the insurance payments of lower income patients (especially of union members in the case of Kaiser, and city employees in the case of HIP.) Despite continuing complaint by patients, often funneled through union or group representatives, these medical plans are generally rated as offering good medical care. Certainly their growth reflects general satisfaction with their performance. Yet a number of informed guesses can be made about how their medical care probably is adversely affected by a mismatching between their internal organization and the life styles of their lower income patients.

Many of those patients are regularly entering the medical care system for the first time. They have not had much, if any, experience in finding their way around within these typically complicated medical settings. "Finding their way around" includes, in some medical plans, discovering a clinic doctor whom one can trust or at least like. By contrast, higher income patients in these days seem typically to have resources—including both people and strategies—that permit them to discover and hang on to the same physician [34]. There is a pervasive anxiety among new patients that they get "a good doctor", an anxiety not always relieved. Yet many lack resources for getting a doctor with whom they will feel satisfied. Since they are likely never to have had a private physician, at least not regularly, they are additionally anxious about how to find one. Another aspect of entrance into a big medical system is the difficulty many encounter when faced with large, multi-segmented, clinics. Despite internal traffic systems instituted by the clinics, patients are often very confused, and this affects the whole tenor of their responses to the medical setting.

Still another complication affecting the quality of care is that unions supply patients to these plans who sometimes tend to see medical care as a labor commodity. You pay your money for service and you should get a fair return! In consequence, the clinic and hospital personnel feel these patients are "demanding," and certain unions get the reputation of being "difficult". But in their turn, the patients may feel the personnel are high-handed. Union representatives do negotiate standard complaints from time to time, in meetings or over the phone with representatives of the medical establishment. Such negotiations are unquestionably useful, but both parties tend to see only the most standardized, most visible, difficulties in giving and getting good medical care. (We know this from interviews with lower income patients.) In addition, both parties are likely to be very busy with other matters, so that grievance negotiation has not the highest priority.

An official of one medical group has noted in private conversation that the bulk of complaints received are from new patients, who also reflect higher drop-out rates; yet his group has done little about investigating the causes of complaint and drop-out. At another group, researchers are discovering that drop-outs are "new patients" who are also of lower income. There is some possibility that these medical groups will be tempted to increase their higher income clients at the expense of lower income ones, unless they look carefully at critical points where their medical organization is mismatched with lower income life styles. In any event these medical groups have *not* directly confronted that mismatching, and until they do, their medical care is subject to the same criticism which we have directed against other medical establishments.

One additional important trend that suggests a continuing pessimism about improved medical care for the lower income groups. The continued conquest of acute disease means that the patient population consists increasingly of people with chronic disease—frequently multiple chronic disease. Lower income families, of course, suffer from more chronicity but also from more multiple chronicity. Especially as their numbers reach middle age, this chronicity shows up when they themselves feel something must be done for their symptoms. By contrast with acute disease, chronicity implies more visits to clinics, longer stays in hospitals, more alert patients, more need for communication between patients and personnel, and a need for much better teaching about self-care and regimens to be carried on at home. This national trend toward chronicity will tend further to acerbate relations at medical settings between staff and the lower income patients.

A case study: Psychiatry

Now I wish to suggest what increased lower income consumption of medical services may mean for particular medical specialties. Psychiatry will be used as one suggestive case study.

During the last decade, psychiatry has grown enormously as an out-patient specialty, has experimented with new treatments, developed new kinds of facilities, and grown greatly both in number of practitioners and consumers.

Quite clearly the patients are going to profit from an increased attention and an increased allocation of resources. At the same time, the professionals do not focus very much, or very directly, upon the potential mismatching of the evolving medical (psychiatric) organization with the life styles of lower income patients. The same kinds of middle class bias are shown, although expressed or rationalized by psychiatric terminology. The communication gap between patients and professionals is not necessarily lessened either, just because psychiatric professionals are more sensitized to the nuances of human behavior than are most other

health professionals. After all, there is a great difference in the experiences of professionals and patients, a difference compounded by the specialized training and stances of the professionals. There is distinct danger, for instance, in the community psychiatric movement, that the professionals will assume they know a great deal about the communities and family settings of lower income patients—when really they do not. Most serious of all, perhaps, is the assumption again that professionals know what is good for these patients—after all, we are the experts and they are the non-knowledgeable, and sometimes uneducated [35].

Responsible public officials and allied professionals are planning along rather traditional lines. Committees have been instituted to deal with familiar categories: such as retardation, addiction, alcoholism, hospitalization, clinics. In many municipal psychiatric services, this organizational defect can be easily seen. Over the last decades, the typical municipal system keeps adding an alcoholic clinic there, a day-care center there, a rehabilitation center, another psychiatric service at the city hospital, and so on. Each establishment has a vested interest in supporting its own continuance. Traditionally there has not been very generous financing of this decentralized municipal system. Now with more funds flowing into the care of their lower income clientele, one can anticipate further expansion of the whole municipal system—without very much focus on how it ought to be reorganized in the light of what life is actually like for lower income people.

One further danger, especially at those locales where the lowest income group tends to flow for treatment, is that the professionals there will become decreasingly discouraged with the results of attempts at treatment. It is predictable that if they do not take carefully into account the life styles of their patients in organizing these medical settings and the treatments given there, the results will prove disappointing to many of the professional staff. Among them will be the more adventurous and ambitious. It is entirely probable that these locales will attract increasingly less competent personnel; or like our present municipal general hospitals, become a way station for young people early in their careers and for foreign trained physicians.

It is not necessary to believe that all this will happen in psychiatric practice. We only sketch the possibilities, and the current situation, to underscore why medical organization needs to be reformed, in terms of lower income attitudes and behavior as well as in other terms. What is true of this medical specialty is surely true of other specialties.

THE LOGIC BEHIND A SET OF RECOMMENDATIONS

The foregoing considerations lead me to believe that *more important than any list of specific recommendations (although several will be advocated) is the necessity for spelling out how such recommendations should be formulated.* A rationale for making recommendations is crucially important for at least five reasons. *First*, sets of specific recommendations can be useful, but hardly scratch the surface of the larger problem of how to destroy inequities among income groups concerning the medical care they receive. *Second*, action guided by recommendations may even aggravate the situation unless one keeps clearly in mind the larger picture of how lower income people regard health and medicine. *Third*, specific recommendations can easily be generated by innovative persons, once the general rationale for making recommendations is clearly perceived. *Fourth*, some of these latter innovations can be put into operation without additional money, resources, or manpower. *Fifth*, as additional resources of any kind become available, they will be most effective when used according to a rationale such as developed below.

It should be evident that the medical care of lower income groups is characterized by a vicious cycle. It is absolutely necessary to break the cycle. Of what does it consist? These patients come into the medical system rather later than they should, principally because they come for care only when they themselves perceive a real emergency. When they enter the clinic or hospital, they have experiences there which are likely to reinforce negative attitudes toward medicine and medical facilities, and cause them either to cut down necessary revisits for care, or if that is not necessary, to make them less eager to return when next they begin to think they might need medical care. But there is another aspect of this vicious cycle. While at the clinic or hospital, there ought to be effective communications to the patient (and family) about measures he should take after he leaves for home. These measures may be medical (taking medications, for instance) or more obviously involve adjustments in daily living (resting, staying home from work). The more chronic the disease, the more likely is the patient to be on a long-term regimen, involving either medicine or daily adjustments or both. Since communication about such regimens at the clinic or hospital is glaringly ineffective, what is done by the professionals at those sites can become partly or wholly neutralized after the patient returns home. In consequence, he gets sicker again, faster; or his chronic disease gets progressively worse, faster. If he had understood his regimens, he may not have had to return at all to clinic or hospital, or at least he would have returned in better shape or after a longer time in relative health. If, in addition, the patient has developed negative attitudes against medical personnel, he dallies in returning for medical care even though his condition really necessitates treatment.

The problem, then, is how to cut into this cycle effectively. To some extent, additional financing of lower income people helps, because then they tend to enter medical care sooner; under certain conditions (union insurance) they can even be bolder in their demands of professional personnel. Additional manpower and other resources help also, by cutting down the ratio of patient to personnel, decreasing waiting time for patients, easing the rush and associated tenseness of personnel, and generally increasing the purely technical efficiency of treatment and diagnosis connected with more time and better equipment. But additional money, manpower or resources cannot by themselves really break the cycle depicted above; they only mitigate it slightly.

Logic leads to the following directives for attacking the cycle. *First*, speed up the initial visit made by the patient for medical care. *Second*, improve the experiences which the patient has in medical facilities. *Third*, improve the communication, given and received, about any forthcoming necessary regimen (usually there is one). *Fourth*, increase the likelihood that the regimen will be properly carried out at home. *Fifth*, increase the likelihood of necessary revisits to the medical establishment (that is, prevent complete defection from medical care). And *sixth*, decrease the time between the necessary revisits for care.

Quite obviously those directives involve changes in medical organization and in professional attitude as well as perhaps some efforts directed at changing lower income attitudes, actions, and styles. Since attitudes and styles are notably more difficult to change than organizational structure and procedure, most recommendations should be directed at changing organizational structure and procedure. Naturally, we will not wish to institute changes that will work to the detriment of contemporary medical organization. Nor would we wish to impair the medical care to higher income afforded by contemporary medical organization at the expense of slightly improving the care offered lower income patients. The problem is to improve the care of all income groups. It is worth emphasizing that the vicious cycle noted above operates although to lesser extent with higher income patients.

My recommendations as given below are meant also to improve care for these patients.

Care received by lower income clientele quite possibly can be improved *without* the expenditure of additional money, and without additional manpower or other types of resource. Improvement can be brought about by rearrangement of tasks, and by reorganization of organizational structure, by inventing new organizational mechanisms and by the reallocation of expenditures. Nevertheless, some changes may require additional resources.

Even more important, whenever additional resources are put into the medical care system, planners can profit greatly by considering both the vicious cycle described above and the specific recommendations noted below. *If money, manpower, and resources are placed according to such recommendations, they will go a good deal further toward conquering that vicious cycle. Otherwise, as suggested earlier, they may be wasted* [36].

RECOMMENDATIONS

The following recommendations are directed at destroying the vicious cycle which marks the medical care of lower income groups (see p. 163).

The recommendations suggested below are only a few among those required to break the cycle. Experienced medical planners and health professionals can add to this list of recommendations, or modify it for particular medical facilities. Their recommendations, however, should be directed at breaking the vicious cycle and derive from considerations of the life-style of the populations who are of particular concern.

Speeding up the initial visit

Detection. (1) *We recommend that there be continued extension of extant methods for detecting illness among lower income people* (see especially pp. 155–157). But these methods can be intensified, and added to. For instance there could be more innovative use of mobile detection units. There could be drives against particular diseases, with attending publicity, especially drives directed at categorical illnesses which are visibly incapacitating or painful to the people themselves. And representatives of the population itself should be given some initiative in planning the drive so as both to enlist support and get effective ideas from the population.

(2) *One obvious agency for detection should be vastly improved, and that is the use of the school for detecting illness.* Currently the school nurse's effectiveness depends largely upon her own initiative. A much more active commitment to the school as a detection locale is required. The age pyramid of lower income groups is more weighted toward children and parents are less likely to detect illness than in the higher income groups. This makes the school a crucial detection locale for lower income illness. The detection effort requires more energy, more manpower, and certainly more and better organization. Certainly teachers could much more effectively be used.

(3) *Sub-professionals, and ordinary family members might be utilized in imaginative ways for detecting illness.* For instance, sub-professionals can quickly be taught to recognize the symptoms of certain diseases common to lower-income populations. Edgar Snow has described, in a recent book, how the Chinese have utilized sub-professionals and lay family members in drives against common categories of diseases. In America, we can surely do likewise both in drives against specific diseases and in also more general detection. This is especially feasible in housing projects and other more organized communities. It is also feasible for unions, governmental agencies, and other employers to organize general or

specific detection efforts. Health insurance companies should encourage these efforts which, although they might initially increase flow to medical facilities, would ultimately benefit both the insured and the insurance companies. Sub-professionals can also be used at the schools for effective detection.

Facilitating the visit

Detection is not enough: the patient must be willing, or able, to go to a medical facility for the requisite treatment. Therefore:

(1) *Although health professionals are understandably reluctant to decentralize facilities for giving treatment, probably the total effectiveness of medical care could be much improved by some decentralization.* (The motto might be, better less perfect treatment than less or no treatment.) (See especially pp. 153-154.) The more centralized are the medical facilities, the less readily lower income people use them. The numbers of treatment centers within or close to lower income housing or neighborhoods should be greatly increased. These centers would function not only to treat but to refer patients to facilities when more extensive or complicated resources are needed. (One Children's Bureau program suggests a useful pattern: prenatal diagnosis and management near lower income residence, with high-risk pregnant women referred to a central facility. Some of these decentralized centers might be manned by trained nurses (or at psychiatric centers, by social workers and psychologists), with adequate provision for referral to more fully staffed centers when necessary. For inducing competent professionals to work at such decentralized centers—mainly located in "poorer" or "undesirable" neighborhoods—it may be necessary to reward with higher salaries, or to offer comparable psychological rewards: good team relations, a "good environment" in which to practice medicine, and the like.

(2) *More extensive and organized methods for making it easier to visit a distant facility are required.* (Dr. Julius Richmond of "Head Start" has described one such method used in Rochester where extensive busing of mothers to facilities is carried out.) Use of sub-professionals, and volunteers, for accompanying children from school to clinic would help to overcome the professional's common complaint that, though the school discovers dental and eyesight deficiencies, the parents fail to get the children to the clinic! The same agents could be used to "cover" for the mother at home, while she takes her sick child to the clinic. [39] In general, research such as that carried out by Hylan Lewis (on lower income Negroes) shows that mothers actually recognize such symptomology in their children—but cannot afford time, money or dare to leave their other children alone at home, in order to take the sick child to the (often distant) clinic unless his condition seems critical. Block organization, or church organization, should be encouraged also toward the goal of "covering at home" for mothers.

(3) *Organized drives to get people, and especially children, into treatment can perhaps best be developed around drives against specific illnesses (see especially pp. 156-157).* This would link detection with treatment in relatively efficient ways, and at the same time arouse public attention in lower income neighborhoods. Unions, churches and places of work could also get involved in such drives. Sub-professionals and volunteers, especially those drawn from the same ethnic groups or social backgrounds as the potential patients, might be especially effective in facilitating visits to medical centers: recent research suggests, in fact, that people of different ethnicity are susceptible to different kinds of social pressure or inducement in seeking medical aid [38].

(4) *We recommend that there be much more extensive institution of evening and night clinics* (see especially p. 149). Given the employment patterns of lower income families, daytime hours are simply unrealistic times for their members to visit clinics. The more extensive institution of evening and night clinics would mean some drastic changes in the lives of some health professionals—and probably increased salaries as inducement—but seems well worth the effort and money. (This change would also remove some pressure on emergency services of municipal hospitals, since these tend to be used during evenings as a substitute for daytime clinics.)

(5) *Every effort should be made to bring pharmacists explicitly into the medical picture* (see especially p. 157). Lower income families are quite likely to use the neighborhood pharmacist for self-prescriptions or counsel before they will go to a clinic or to a private physician. Unrealistically, health professionals tend to regard the pharmacist as having a very prescribed role. The pharmacist needs to be geared in more rationally with a referral system, induced to persuade patients to enter clinics when they seem to need treatment or diagnosis. This will not necessitate alteration of current medical organization; but it will involve additional organizational mechanisms, such as the contacting and rewarding of pharmacists. (Rewards need not necessarily be monetary but of prestigious kinds.) There should be some training in detection of common diseases (as dentists are now taught to recognize oral cancer). Schools of pharmacy can greatly help in this training, especially perhaps in post-degree workshops. Other types of health healers should also be regarded as potential agents for getting patients to clinics sooner, rather than, as now, only as rivals of conventional medicine. Their referral functions can also gain these rewards if the professionals and public will pay attention to the genuine value of the functions.

(6) *We recommend consideration of methods of rewarding lower income patients, providing they enter treatment early, be carefully considered* (see especially pp. 156–157). While such rewards might work better to induce speedy re-visits, they might also be effective, and financially feasible, for inducing a speedier first visit. It would be worth money to health insurance companies, and to the various federal and local governmental agencies, if patients entered treatment earlier rather than waiting until their illnesses were further along.

Improving experiences within medical facilities

(1) *We recommend that the emergency services of municipal and county hospitals be radically reorganised* (see especially pp. 150–152). Lower income people use emergency services not only for “genuine emergencies” but as a substitute for a general practitioner and for a clinic. A great many emergency services are, therefore, unrealistically and inefficiently organized. General service gets in the way of effective emergency service. Staff biases toward lower income patients are reinforced by the wear and tear of running dual medical services, side by side. Patients resent the attitudes and behavior of staff, and frequently do not understand why they are “taken out of turn”. Also, they tend to flood the services during the evening, when family members are free to visit for treatment. Therefore these services should be reorganized, in accordance with the needs of specific locales and types of client; but with full realization (rather than resentful begrudgement) that if lower income people use emergency services for general medicine, then there must be a good reason for such use. Again, representatives of the local populations might contribute greatly to instituting effective reforms.

(2) *Clinics and hospitals should assign personnel to act as agents for patients in medical establishments* (see especially pp. 148–154 and 156–159). Lower income patients need those

agents for a series of reasons. They need to be oriented in institutional structures that are otherwise unduly or altogether confusing. They need to be informed better about a variety of matters than is now ordinarily the case. They need more reassurance, allaying of inappropriate anxiety, and other "psychological care" than they get under current arrangements. And they need, especially, an agent who can negotiate for them with hospital or clinic personnel, since they lack the effectiveness displayed by higher income patients in negotiation. Sub-professionals might often be especially useful agents for certain patients and their families—and their use should be made central rather than peripheral in future medical organization. In-service training in such functions should be available, whether the agents are sub-professionals or professionals.

(3) *Hospitals and clinics should build additional important types of "accountability" into their organization of care* (see especially pp. 156–159). By accountability is meant the assigning and reporting back of certain kinds of tasks and their accomplishment during the day's routine. The report includes information about the patient, of course. Much other information that the personnel now obtains, from or about a patient, is passed along to responsible authorities fortuitously—if at all. For instance, the nursing aides commonly know a great deal about hospitalized cardiac patients which would be relevant to the nurses and attending physicians, but that information is rarely requested nor are the nursing aides usually queried about it. Whether or not these personnel are trained in the deeper meanings of such information, they ought to be held accountable for reporting it. The same can be said for information possessed by all personnel about terminal patients in hospitals [39]. Indeed the nurses' aides can be taught to recognize—if not fully understand—types of symptoms and other information which otherwise is never picked up by the professional staff. Such information, of course, includes behavior and attitudes which the aides are in an especially good position to see. If the patient's background is similar to the aide's, her report may be especially valuable to the staff. This recommendation about accountability is closely related to the previous recommendation about the patient's agent. The increased range of accountability would not only directly improve medical care; it would increase the patient's appreciation of that care, so that he would feel better about his experiences when in the clinic or hospital.

(4) *Wherever possible the medical facilities which service lower income patients should be made more in accordance with tastes and life styles of the patients.* This includes furniture and other items as well as spatial or room arrangements. Apart from their purely functional aspects, and limits placed by finances or overcrowding, the designs and atmospheres of medical facilities seem not well suited to making lower income patients feel psychologically at ease. At their worst, these facilities are really forbidding or repelling—as in one municipal hospital where a dense mass of colored patients sits daily while waiting for the individual calls, as if they were in a grim bus station. Again, representatives of patient populations can give good cues to how even old facilities can be made more comfortable and "normal".

(5) *We recommend—as an absolute necessity—attempts at training health personnel to lessen their prevalent class and professional biases against lower income patients* (see especially pp. 151, 152, 157 and 161–162). Since the changing of attitudes is usually more difficult than instituting changes in organization and procedure, this recommendation implies a long-term program. In-service training will be useful, but the training received in professional schools is likely to be most effective in the long run. Such training is virtually non-existent in schools of medicine or nursing [40]. Schools of medicine need especially to face this problem, since their highly technical orientations—increasingly technical, if anything—leave little room for this kind of training, at the same time that their graduates will increasingly be in contact

with lower income clientele. Teaching programs that insure greater contact with families and communities are a step in this direction, but are not enough. Social science teaching needs to be built systematically into even these programs.

(6) *In addition, medical educators need very much to innovate new organizational links between teaching hospitals and medical schools in order to ensure a more extensive contribution to lower income health* (see especially pp. 152–153). The need for inventive—and honest—thinking about this problem is rendered even more urgent by the increasing role assigned university medical centers in the health organization of the nation.

(7) *Medical facilities should carefully consider how they might improve the lodging of complaints against their services by their patients* (see especially pp. 149–150, 152 and 160). The lower income patient and his family have few resources for lodging effective complaint when dissatisfied with medical services; especially after he has returned home. (Higher income clientele are much more skilled at conveying grievances and possess many more channels of effective protest.) Unions whose members have purchased health insurance currently negotiate complaints but tend to focus only on rather obvious ones, and probably many unions wait for grievance reports from members rather than effectively seeking them out. Medical groups currently suffer the defection of new members rather than rationally attempt to organize a grievance process. It might even be feasible to build certain kinds of standards into health insurance to maximize the probability that grievances would be aired and met, when possible, by medical establishments. Again, representatives of populations served by the medical facilities might well be useful in articulating and funneling grievances. When more effective grievance processes have been organized, lower income patients will feel less helpless at clinics and hospitals—and certainly more inclined to turn to them for care.

Improved communication about regimens

Almost all patients who visit clinics or stay at hospitals must be put on at least some minimal regimen when they leave for home. Yet, communication about regimens tends to be ineffective with lower income patients. In busy clinics and hospitals, the professionals are focused primarily upon diagnosis and immediate treatment. This is what physicians and nurses have been trained to do with great professional skill. Explaining regimens is a far less professionalized activity. Middle class and professional biases of personnel are further obstacles to careful explanation. When good explanations are actually made, the patient may not understand either its details or its rationale because he is still too ill, or too gripped with anxiety to listen carefully.

(1) *We recommend therefore that considerable thought be given to this problem of how to convey the sense of regimen to patients* (see especially pp. 150, 152–153 and 161–162). Even a busy clinic or hospital can be somewhat reorganized so that more care is devoted to communicating regimens. In some areas, like diet, there seems to be genuine confusion over who communicates what to the patients [41]. There should be a clearer division of labor worked out in those presently confused areas. Sometimes communications are too brief because the physician is busy, when a nurse might just as well communicate the regimen. Ordinarily there is little or no attempt to follow up on whether the communication has been correctly understood: sub-professionals might usefully interview patients shortly after professionals have communicated regimens to check on whether patients understand what they have been told. With complicated regimens, nurses probably should do these interviews.

(2) *Special training should also be given to improve the ability of professionals to com-*

municate regimens. Since they now receive little or no training in this skill, it is necessary that much more attention be given to this problem in schools of medicine and nursing. In-service training at the interne-resident level, and for nurses, would also be useful. This training should not focus merely on how professionals should talk to patients; but also how to interview them about whether they can or care to follow those regimens, and how to listen to their questions about the regimen. Since professionals are not ordinarily trained either in interviewing or in listening to patients—and since lower income patients tend not to press their views on professionals—training in those special skills is particularly necessary. Social scientists have developed excellent interview methods but they are little used for teaching them to medical or nursing students. When patients frequently fall into certain foreign language groups, nurses at least should be asked—even paid—to learn one language at least. And there should be a full time interpreter at the facility.

Checking upon home regimens

Even when the patient and his family understands his prescribed regimen, when he returns home he may not follow it correctly. He may not have understood all its details. He may be discouraged by its rigor. The family's style of life may mitigate against his following it closely. Sometimes he has not really understood the regimen because told about it too early, while still confused in the hospital. And, of course, very often he has not understood the regimen at all. But if he does not follow his regimen with some accuracy, he suffers the consequences—and so does the clinic or hospital, because he returns all the sooner.

(1) *We recommend therefore that clinics and hospitals attempt to organize their services to include checking on the regimens of ex-patients who have no private physician* (see especially p. 153). This re-organization might include a number of measures. Patients should be encouraged to telephone specifically assigned personnel for queries about regimens, and possibly personnel should contact patients to solicit queries. At many locales it should be possible to get closer collaboration between clinic or hospital and the public health agencies, precisely around the issue of regimen checkups. Probably we also need to build in additional types of personnel responsible to agency or clinic/hospital. Sub-professionals might do certain kinds of checking upon regimens, but where the patient is sicker or the regimen more complicated (perhaps involving more equipment) specially trained nurses may be necessary to mitigate this portion of the vicious cycle in medical care. The medical care system *must* take responsibility for this kind of feedback of communication with lower income patients—and the responsibility *must* be institutionalized.

(2) *In lower income locales, the hospitals and clinics should attempt to bring the local physicians into some sort of association with the medical facility* (see p. 157). Many of these physicians operate without hospital connections, practice deficient or old fashioned medicine, and yet are often in contact with patients after (and sometimes before) he goes to, or is referred, to the clinic. Often the patient prefers after leaving the clinic to go to the doctor down the block, either because of other minor ailments or because he has not really understood what the staff told him at the big establishment. Therefore a determined attempt to connect the local physicians with clinics and hospitals will not only help educate these men; it will help the patient after (and sometimes before) he leaves the clinic or hospital.

(3) *Medical establishments should make special efforts to discover something about the prevalent life-styles of their patients.* One major block to correct or persistent adherence to regimens is the family's life style (see especially pp. 150–151, 161 and 162). This effort will require special studies by social scientists, or at least special interviewing by responsible

personnel. Too much is now assumed about the lives of patients—either they are supposed to live no differently than anyone else, or they are perceived as living so differently that they will not follow regimens correctly no matter what told. Both types of assumption are likely to be proven incorrect once the patient's life is really understood. It is necessary to understand the social backgrounds and home life of patients reasonably well, otherwise regimens cannot be communicated accurately nor followed closely at home.

(4) *Imaginative attempts should be made to create a medical technology, for use at home, of the utmost simplicity or that relies as little as possible on patients' judgment and motivation* (see especially p. 153). The long-working tranquilizers now being experimented with on mental patients are instances of such technology; so is, in its own way, the contraceptive "loop". Given some of the characteristics of lower income life and attitudes toward the body, the more such technology can be invented the less need patients be given complicated regimens (which involve repeated actions, good timing, persistence, and so on). This technology may evolve by itself, but special focus upon its benefits for lower income patients might speed its evolution.

Decreasing defection from care, and decreasing the intervals between necessary revisits

I shall not offer special recommendations for these two, final, segments of the vicious cycle in medical care. The preceding recommendations bear quite directly on both these segments. Innovative re-organization of medical services need only extend or add to those recommendations to affect defection or decrease intervals between necessary revisits to clinic or hospital [42].

FOUR LEVELS OF RESPONSIBILITY

Obviously some of the above recommendations are not original, and various medical facilities have been experimenting in similar directions [43]. What makes these recommendations different is that they are related to each other through the guiding idea of the "vicious cycle." A principal argument of this paper is that equity of health care cannot be obtained unless all portions of the vicious cycle are attacked simultaneously. A scattered, piecemeal attack will simply not do the job.

To insure sufficiently broad action to begin genuinely to break this cycle, one further, very general, recommendation is necessary. This recommendation involves four levels of responsibility: professional, institutional (clinic/hospital, etc.), lay, and governmental.

(1) *The professional societies and schools must take responsibility for certain reforms bearing on the total vicious cycle.* For instance, vigorous and imaginative steps should be taken by schools of medicine and nursing in order to counteract the prevailing class bias of their students, and to teach them how to communicate much better with lower income patients. Surely they need to attack more seriously the problem of relating schools and teaching hospitals to community realities. Professional societies like the National League for Nursing and the American Nursing Association can be instrumental in furthering sub-professional training and in instituting better use of the nursing aide on nursing services. The more aware of the total difficult cycle are the associations and the professional schools, the more effective can they be in attacking it across the board.

(2) *Likewise, specific medical institutions might act on specific recommendations offered above as well as on recommendations they have thought of themselves—but they should also consider how broadly across the total cycle they can spread their action.* They bear the responsibility for attacking all six segments of the cycle, not just bits and pieces of one or

two segments. Most programs of reform are relatively ineffective, it is safe to say, because they are based on such partial attacks. At the very least if a hospital, for instance, cannot take responsibility for surveying the patient's regimens when he is at home, then vigorous attempts to gear its programs with those of public health, and other community agencies, should be made [44].

(3) *It would seem absolutely foolhardy not to enlist the responsible efforts of lower income people toward the goal of getting them better health care.* Many of the recommendations listed above involve the use of sub-professionals drawn from the same income groups as the patients who are being serviced. Other recommendations urge the cooperation of "community" representatives, for example in instituting grievance procedures and improving detection of disease. Some lower income populations constitute relatively genuine communities or neighborhoods (especially ethnic groups, like the Polish-Americans who tend to live in parishes), and they could be effective contributory agents in improving health care. Some populations, however, in no sense whatever constitute "communities"—entire city blocks being composed of isolated families (or fragments of families). Getting lay representation for the latter people is a much more difficult problem. Each medical facility must make special efforts to determine what kind of representation its patient populations can manage—and the facility must help in organizing that representation. But not so rigidly, or with so much authority that lay representatives meekly follow directives. It should even be possible, and useful, to get lower income representation on advisory boards for those clinics and hospitals which service mainly lower income patients. Also, wherever there are genuinely indigenous community organizations, medical facilities should seek to urge and get their cooperation in the common enterprise, without getting captured by particular perspectives often characteristic of specific community organizations [45].

(4) *Finally, governments (at varying levels, from city up through federal) have an immense responsibility* for persuading, inducing, or pressuring medical institutions and health personnel toward reforming our system of medical care. If governmental agencies were guided by the concept of "the vicious cycle," their influence on reforming medical organization would be measurably greater. While our citizens wish a great amount of "free choice" and "free enterprise," these are not of course incompatible with the institution of regulatory mechanisms by responsible governmental agencies. My argument is that without such regulatory mechanisms—directed according to some such conception as "the vicious cycle"—much of the money spent on improving medical care will be wasted, and even on occasion harmful. The so-called "trickle down" approach—with moneys funneled out by governments for additional equipment, manpower, beds, research and construction—must be anchored in an appropriate organization at the local level. This problem is all the more pressing, as indicated earlier, because influence is shifting rapidly to the elite medical centers, which in some instances are far removed from lower income concerns and perspectives [46].

EPILOGUE—THE CONVERSION OF LOWER CLASS STYLES

In closing this paper, I wish to counter one type of potential criticism based on unwarranted optimism about changes in the life and attitudes of the lower income group. Let us assume, it can be argued, during the next two or three decades that the notion succeeds in raising the standard of living of all citizens to such an extent that all become more or less "middle income" citizens. If that occurs, and even such a skeptical economist as Robert Heilbroner admits this possibility [47], then it seems reasonable to suppose that an

accompaniment of increased incomes will be a substantial increase of middle income life-styles—including those most relevant to effective medical care.

This assumed association between income and life-styles is not at all certain. It may even be a dubious assumption. For instance, there is some evidence that although the increased incomes of skilled workers since World War II have resulted in increased purchases and consumption, nevertheless the life-styles of these Americans have not rapidly approximated those of white collar, business and professional Americans [48].

Indeed, certain groups in our population might be raised a number of notches in income without radical changes either in life-styles or in utilization of our system of health care. These groups have long elected to stand a little outside the mainstream of American "middle class" striving for status, increased income, and other conspicuously middle income values. I have in mind, for instance, the large Polish-American and other slavic groups in cities like Chicago and Cleveland. As various sociologists have noted, these groups remain relatively low in income, produce relatively few "upwardly mobile" families, and retain a fair degree of older and certainly lower income values. Increased income, and even increased patterns of consumption are not likely to institute or constitute radical changes in their life-styles.

It is, I would contend, simply too optimistic a view that would maintain: "give them another two or three decades and they will efficiently be serviced by our health services". Even if this contention were true, the consequences of the "wait out" period ought critically to be reviewed. Efficiency, let alone compassion, demands such a review. Meanwhile a little tinkering here and there, a few reforms here and there, and even a great deal more money allocated to our health services will hardly give anything like the promised equality of care.

Is the United States unique?

I wish to add a note about the probable relevance of my argument to conditions in other countries. Of course, there are great differences between the United States and other nations, and between their respective systems of medical organization. Many countries have more universal medical coverage and so perhaps their health personnel have had more experience with lower class patients. Less industrialized countries have less massive organizations for health care than does the United States. The dominant private practitioner control of American hospitals is in marked contrast to state-organized medicine elsewhere. The continental size of the United States, the diversity of its population and complexity of its class structure lead to sharper differences between staffs and patients than may obtain in smaller countries, or in lands with more homogeneous populations and less complex class systems. And many governments in non-industrialized countries—principally in Asia, Africa and South America—recently much interested in the health of their citizens have focused strongly on bridging the gaps between western medicine and native beliefs and practices.

Despite such provisos, I suspect many details of my paper are applicable to many other countries. Suppose one thinks of a continuum running from countries (or areas of countries) where modern medicine predominates to countries (or areas) where it is hardly practiced. In nations which fall toward the latter end of the continuum, large portions of their populations are relatively unacquainted with western medicine and its implementing facilities. The gap between modern medicine and native practice, belief, and styles of living are much like the gap depicted in the foregoing pages. In addition, there may be sharp ethnic and/or class differences between the health personnel and various sectors of the population in these

countries. Or the personnel are so westernized (or in Europe, scientized) that they no longer empathize with, or have patience with, attitudes of their own ethnic groups. Moreover the staffs are likely to have less control over the carrying out of regimens, once patients leave the medical facilities, than do personnel in the United States. And if the patient is well motivated and understands the regimen, native or local life-styles are likely to prevent his faithful following of the regimen.

About the more industrialized and urbanized countries, perhaps all that needs to be said here is that—despite the even greater scope of population under medical care than in the United States and greater governmental control of medical organization—much the same model of medical training and medical “treatment” exists. Also, it is probable that the prevailing national organization of health care surely is least effective in those regions which are least urbanized or industrialized. For countries in the middle range, my own observations have suggested that except in the central cities—and there not even with respect to recent immigrants from their hinterlands—the mismatch between organization of medicine and the actual care of patients is great, sometimes greater than in the United States with regard to our lower class patients.

Only comparative studies can tell us how, where, and to what degree such mismatching exists around the globe. Such studies are badly needed. Meanwhile policy cannot stand still. Nevertheless, policy makers in each country might profit from thinking within the framework offered here. Especially I would emphasize that plural systems of medical belief and practice exist in all countries, and at every class level; hence the conclusion that health officials and personnel everywhere would do well to come more directly—and imaginatively—to grips with the problem of meshing their own systems of medical care with the plural medical observances and life-styles of all segments of their populations.

REFERENCES

1. Most of the data on which my argument, and critique, is built are readily available. I have used mainly the published research of social scientists about lower income life-styles and utilization of medical services. In addition, I am in heavy debt to Drs. Eliot Freidson, Lee Rainwater and Melvin Sabshin, for extended memos (including recommendations) dealing with aspects of medical care as related to lower income populations, and to Dr. Hylan Lewis for research materials on Negro family life; and to Shizriko Fageshaugh for very useful interviewing. Robb Burlage, of the Institute for Policy Studies, offered many ideas in a careful reading of a first draft of this paper. Of course I drew also on my own experience as a sociologist who has had considerable research experience in medical areas both in the U.K. and abroad.
2. See *New York Times*, January 8, 1965, p. 16.
3. Public Health Service Publication No. 1000—Series 10—no. 9, issued May, 1964. The report is based on data collected in household interviews.
4. Four categories of family income are compared throughout this government report. The two lowest income groups are, respectively, Under \$2000 and \$2000–\$3999. The next two classes are, respectively, \$4000–\$6999. The population of all ages for July, 1962–June, 1963 in the United States was approximately for each of the above income categories: 22,590,000; 32,485,000; 61,675,000; and 57,082,000 (9,334,000 were of unknown income.). Thus the two lower income groups constitute a high proportion of the American population. In percents of the total population (183,146,000), they constitute, respectively about 12 per cent and 18 per cent. (See p. 168).
5. From his abstract of *The Changing Roles of Government in Health Affairs, Implications for the Future*, delivered on April 30, 1965.
6. ARTHUR LESSER, *Current Problems of Maternity Care*, U.S. Department of Health, Education and Welfare, speech delivered May 10, 1963.
7. In a more general context, Dr. GEORGE SILVER has made a similarly strong statement. Summarizing certain findings in his *Family Medical Care: A Report on the Family Health Maintenance Demonstration* (Cambridge: Harvard University Press, 1963), he remarks that “Nor is utilization based simply on economic access or availability. In this light, one of the arguments used for (and against) compulsory health insurance loses considerable force. It isn’t only economic factors that serve to deprive people of

medical care, and equally it isn't true that removal of the economic barrier will inundate the doctor with unnecessary demands for service. *The present organization of medical practice is defective and that is what leads to inadequate service on the doctor's part and improper use on the patient's part. Consideration should be given to restructuring medical practice: provisions should be made for the added time, family interest and concern, skills in guidance, and perhaps team approach, that would enable the professional people to understand and cope with the complex variables of patient demand and use.*" (p. 151). Italics not in original quote.

8. As ALONZO YERBY, Commissioner of Hospitals of New York City, summarised in his "The Disadvantaged and Health Care," a paper given at the White House Conference on Health, 1965, "Health care of the disadvantaged is piecemeal, often inadequate, underfinanced, poorly organised and provided without compassion or concern for the dignity of the individual. It remains as a legacy of the Poor Law, little changed in concept or application while discoveries in medicine and other health sciences have advanced with lightning speed. Certain groups of the disadvantaged in America, notably the Negro, get even less than their share of health services even though there is ample evidence that their needs are greatest. We can no longer tolerate a two class system of health care."
9. Furthermore, failure to reorganize efficiently may help to lower quality medical care for higher income patients. Increasing numbers of lower income consumers will be entering the medical market through increased incomes, voluntary insurance and federal financial underpinning. No planning for reorganization, or planning only in terms of delivering in much the same old ways more medical services to previously deprived Americans, almost certainly will lead to some unfortunate consequences for some higher income patients.
10. DANIEL ROSENBLATT and EDWARD SUCHMAN, *The Underutilization of Medical-Care Services by Blue-Collarites*, in *Blue-Collar World* edited by ARTHUR SHOSTAK and WILLIAM GOMBERG. pp. 341-349. Prentice-Hall 1964.
11. HARRIS PECK, FRANK RIESSMAN and EMANUEL HALLOWITZ (preliminary working draft), *The Neighborhood Service Center: A Proposal to Implement a Community Mental Health Network*, Lincoln Hospital Mental Health Services, Department of Psychiatry, Albert Einstein College of Medicine, pp. 7-8.
12. *Passage Through Crisis*, pp. 56-57. Bobbs-Merrill, Indianapolis, 1963.
13. ELIOT FREIDSON, Notes, of patients who participated in the Family Health Maintenance Demonstration (Montefiore Hospital), that "high social class was associated with a greater degree of sensitivity to insult, and to feeling like a 'charity case,' and with a critical and manipulative approach to medical care. In contrast, the lower classes were somewhat more insensitive to their status as patients and were rather more passive and uncritical in their approach to medical care . . . lower-class patients were more reluctant to 'bother' the doctor and more eager to accept the substitute services of the . . . nurse." See his "Social Science Research in the Family Health Maintenance Demonstration," in GEORGE A. SILVER, *Family Medical Care*, Harvard University Press 1963), especially pp. 233-235.
14. "The Underutilization of Mental Health Services by Workers and Low Income Groups: Causes and Cures," *Am. J. Psychiat.*, 121 (1965).
15. *Ibid.*, p. 799.
16. BERNARD SCHOLZ, formerly Chief of the Public Assistance Division of the District of Columbia Department of Public Welfare, writes:
Frequently we ask . . . patients to bring . . . whatever medications they are taking at the present time, and you would be amazed to see the shopping bags they bring in and the pills, tablets, capsules and liquids of all sizes, colors, smells and descriptions they spread out on the table. Frequently we find that they are under treatment in different speciality clinics for different complaints, and that some of the medications prescribed for them and some of the drugs liberally handed to them at the District Pharmacy may either neutralize each other or in combination cause very questionable side effects . . . We professional people in our well appointed houses, have medicine cabinets cluttered up with an amazing array of save-up medications which we identify, when need arises, and the date when the doctor prescribed it, but here we are dealing with illiterate people, or people with very limited education, who often don't know the name of the doctor who saw . . . and prescribed . . . We give them medications with such white-middle-class instructions as "one after each meal", when actually we mean three pills, six hours apart during the day, but this schedule may have nothing to do with the time (when they eat) . . . From: "Medicine in the Slums", *Clin. Proc. Child. Hosp., Columbia*, 18, 351, 1962.
17. See ARTHUR J. LESSER, *op. cit.*
18. "And I do think the treatment would have been different if Albert had been white. I mean, if the ambulance had of come in there with a little white boy and he had fell off the third floor perch, they would have had everybody in there working on him. They would have called all the nurses to hold him and everything. And they probably thought I wasn't home or something with the kids, and what was the mother doing (when Albert fell—why should they rush.>"). Quoted from an interview document with a negro mother, by permission of Professor Hyland Lewis, Howard University (from his study of child rearing practices in Washington, D.C.).

19. AS JOHN KNOWLES, General Director of the Massachusetts General Hospital and Lecturer on Medicine at the Harvard Medical School notes, "The goals of the medical school are teaching and research—the teaching of medical students and the conservation and expansion of knowledge, all for *tomorrow's* health wants and needs. The goals of the teaching hospital are first and foremost, the care of the sick and service to the community *today*. In instances where teaching and research . . . have dominated the hospital, the attitude has become set that the patient exists for the teaching program and not that the hospital exists for the patient. Selective admitting policies, shabby patient facilities and deteriorating physical plant, wards full of special 'research' patients, failure (or refusal) to accept alcoholic patients or expand emergency facilities, a two-class system of care with frequent town-gown battles within the walls of the hospital and disregard for the out-patient department all lead to a demoralized and spiritless institution. Such a hospital will never send its roots deep into the community for moral or financial support as a consequence of having served the *Community's* wants and needs rather than just its own." He adds, "Only recently have some of our medical school research plans included studies of the patient care and community service functions. This type of applied research has a better chance of giving something to the community which will improve the organization and distribution of health services." See his 'Medical School, Teaching Hospital and Social Responsibility: Medicine's Clarion Call,' delivered at the Second Institute on Medical Center Problems of the Association of American Medical Colleges, Miami, Florida, December 9, 1964. (Quotation on pp. 16–17).
20. ARTHUR LESSER, *op. cit.*, p. 10. See the bibliography for several surveys bearing on under-utilization of prenatal care. See also Rosenblatt and Suchman, *op. cit.*
21. Reported in LESSER, *op. cit.*, pp. 10–11.
22. *Op. cit.*, pp. 10–11, quotation from FRANK MCPHAIL.
23. ROSENBLATT and SUCHMAN, *op. cit.*, p. 349.
24. Quotation from a memo written for this paper.
25. ROSENBLATT and SUCHMAN, *op. cit.*, p. 345.
26. In a study done a decade ago, EARL KOOS showed how, in one small city, the lower income population expressed in word and deed the gap between themselves and physicians, and how they frequently turned to remedies, osteopaths and druggists. About the pharmacist, Koos remarks "His place in the health team was sharply limited by law, but his place in the community suffered no such limitations." See *The Health of Regionville*, Columbia University, p. 87. 1954.
27. As one researcher, NORA PIORE, notes about New York municipal hospitals, "The city tends to get the patient when he is either very sick or wholly unable to afford treatment." Metropolitan medical economics, *Scient. Am.* 212, 19–27, 1965.
28. WILLIAM R. ROSENGREN, Social class and becoming 'ill', in *Blue Collar World*, edited by ARTHUR B. SHOSTAK and WILLIAM GOMBERG. Prentice-Hall, pp. 338–339, 1964.
29. JULIUS ROTH, Institutions for the unwanted, unpublished paper, presented to the Tufts Colloquium on Social Science and Medicine, April 8, 1965, pp. 13–14; see also his monograph, *Rehabilitation for the unwanted* (unpublished).
30. *Op. cit.*
31. ROBB BURLAGE has noted in correspondence with me, that New York City is an excellent example: despite the fact that millions of dollars and much regulatory power has been put into upgrading, affiliating and merging the New York City hospital system in the interest of quality care, there has been little organization *distinctively* for delivery of better care to the lower income population, except for a few hospitals like Gouverneur and Morrisanis.
32. At one community hospital at which we interviewed, the private physicians working at the clinic do not always "behave very well" toward the new patients (coming there on welfare funds) and the young staff physicians openly express adverse attitudes toward these patients, especially when the patients are Negro. More sympathetic staff members acutely feel the gap between themselves and the new type of patient, but do not know how to bridge it.
33. In fact, the whole situation probably will be contributed to further by the federal government's increasingly great financial support of these voluntary hospitals while it offers only loose, minimum-standard regulation governing care of federally supported patients.
34. One lady whom we interviewed, for instance, phoned around among her professional friends, including doctors, for recommendations and finally decided on one particular clinic physician. She phoned the clinic to find his days on duty, met him, and makes sure she attends clinics only on the days when he is at the clinic. She has obtained from him the names of other clinic-physicians whom he respects just in case she needs to be seen when he is not in attendance.
35. The prominent psychiatrist, Dr. MELVIN SABSHIN, has in private correspondence remarked that "many psychiatrists are moving into community psychiatry but not thinking about it very hard. They are moving in a practical sense to develop clinics, develop services, but are not conscious of the necessity for a dialogue between themselves and representatives of the lower classes.

36. And perhaps even sometimes harmful—tending to *increase* the gap between lower income health needs and medical organisation.
37. At one psychological clinic in New Haven, the practice of going directly to the homes to get the patients (children) has been highly successful. (Personal communication from M. LEVINE.) S. SARASON, M. LEVINE, I. GOLDENBERG, D. CHERLIN and E. BENNETT, *Psychology in the Community*. Wiley, 1966.
38. IRVING, ZOLA, Illness behavior of the working classes: implications and recommendations, in SHOSTAK and GOMBERG, *op. cit.*, pp. 350–361.
39. ANSELM STRAUSS *et al.*, The nonaccountability of terminal care, *Hospitals*, **38**, 73–77, 1964.
40. *Cf.*, HELEN MACGREGOR, *Social Science in Nursing*. Russell Sage Foundation, 1960.
41. *Cf.*, MARJORIE NEWTON and ANDE L. KNUTSON, Nutrition education of hospitalized patients, *J. Am. diet. Ass.* **37**, 222–225, 1960; and MARJORIE NEWTON, Are administrators and dietitians speaking? *Mod. Hosp.* **99**, 108–114, 1962.
42. Apropos of these points, it is worth noting that health care in the armed services depends to a considerably less extent on “voluntary” action than does civilian care. Even here, there is considerable defection away from care: men do not necessarily hold to regimens, do not necessarily revisit the medical facilities “regularly” or “on time”, etc. Despite the services’ interest in maintaining some minimum level of health, the organisation of health care is consequently far from always effective. (I am grateful for this observation to Dr. Egon Bittner).
43. For instance, in New York City, Dr. George Silver’s program at Montefiore Hospital and Dr. Howard Brown’s program at Gouverneur Hospital.
44. In a revealing exploratory study, Mary Arnold and Douglas Hink of The California Heart Association, interviewed officials of various agencies and facilities working with cardiac patients in one county in California. They were all working in relative isolation, each assuming some other agency or institution was taking chief responsibility for cardiacs. No one was. (Personal communication).
45. *Cf.*, FRANK RIESMAN’s account of low-income participation in a mental health program, Low income culture: the strengths of the poor, *J. Marriage and the Family*, **26**, 420–421, 1964.
46. ROBB BURLAGE, in correspondence with this author: “The basic public policy questions thus become how to provide adequate *public* control at the top of an increasingly elite-dominated ‘corporate’ contract system and how to provide quality and appropriate care at the ‘bottom’, particularly to difficult cases such as lower socio-economic groups.”
47. “To what extent does that conclusion . . . lead to the prospect of alleviating poverty within the next generation or so? In the short run the outlook is not very hopeful . . . Yet it seems to me that the general dimensions of the problem make it possible to envisage the substantial alleviation—perhaps even the virtual elimination—of massive poverty within the limits of capitalism three or four decades hence, or possibly even sooner.” See his, The future of capitalism, *Commentary*, **41**, 26, 1966.
48. *Cf.*, GERALD HANDEL and LEE RAINWATER, Persistence and change in working class life-styles, *Soc. Social Res.*, **43**, No. 3, 1964.

(Received 31 May 1967; in revised form 6 February 1968)

Résumé—Aux Etats-Unis, quand on parle d’améliorer le système de soins médicaux on souligne le fait qu’il s’agit en effet d’étendre et d’améliorer un système qui est fondamentalement solide. Ce point de départ suppose qu’on peut pourvoir aux besoins des groupes ayant les revenus les plus bas, sans transformer radicalement le système de soins médicaux. Cette supposition est douteuse. Il faut de grandes réformes dans l’organisation de la médecine elle-même. Il faut tenir compte des moeurs des groupes moins riches quand on entreprend d’organiser des soins médicaux pour ces secteurs de la population. Dans cet exposé une série de recommandations est présentée; il s’agit surtout de re-mettre en ordre les tâches et l’organisation, d’inventer une nouvelle technique d’organisation et de redistribuer les dépenses.

Summario—En los Estados Unidos, el énfasis para mejorar la atención médica se da a la extensión y al mejoramiento de un sistema de organización médica de por sí bueno. Este enfoque da por sentado que los grupos económicos bajos pueden ser atendidos sin la necesidad de emprender una transformación radical del sistema de atención médica. Es ésta una pre-suposición dudosa. Son necesarias grandes reformas en la organización médica en sí. Al organizar la atención médica para los grupos de bajo ingreso, debe tomarse en cuenta el estilo de vida de dichos sectores de la población. Este documento ofrece una serie de recomendaciones; dichas recomendaciones se refieren principalmente a una redistribución de las tareas y la organización, a la invención de nuevos mecanismos de organización, y a la redistribución de gastos.

Zusammenfassung—Bei der Verbesserung des Gesundheitswesens legt man in den Vereinigten Staaten den Nachdruck auf den Ausbau und die Vervollkommnung eines im grossen und ganzen gesunden Systems. Diese Denkweise nimmt an, dass die unteren Einkommensgruppen erfasst werden können, ohne dass das Gesundheitswesen von Grund auf geändert werden müsste. Diese Annahme muss bezweifelt werden. Grundsätzliche Reformen des Gesundheitswesens an sich sind notwendig. Man muss die Lebensweise der unteren Einkommensgruppen in Betracht ziehen, wenn man die ärztliche Fürsorge für diese Bevölkerungsschichten organisiert. Eine Reihe von Verbesserungsvorschlägen werden in diesem Artikel angeboten. Die Verbesserungsvorschläge richten sich in erster Linie auf eine Neuordnung der Aufgaben und der Organisation, auf das Errichten von neuen organisatorischen Formen und auf eine neue Verteilung der Gelder.