Community-Based Primary Care

Sarah Banks-Lang

Follow this and additional works at: https://scholarlycommons.henryford.com/hfhmedjournal

Part of the Life Sciences Commons, Medical Specialties Commons, and the Public Health Commons

Recommended Citation
Available at: https://scholarlycommons.henryford.com/hfhmedjournal/vol38/iss2/22

This Article is brought to you for free and open access by Henry Ford Health System Scholarly Commons. It has been accepted for inclusion in Henry Ford Hospital Medical Journal by an authorized editor of Henry Ford Health System Scholarly Commons.
Community-Based Primary Care

Sarah Banks-Lang, MHA*

Whenever a new decade begins we usually resolve to take care of finally and completely the health problems that plague urban communities, and we often believe that the answer is to develop new programs. However, I believe that the model for the 1990s is one that has already been tried and proven and is ready for full implementation to meet the health and human service needs for urban citizens.

Community Health Centers

For a recent government publication on national health objectives for the year 2000 (1), work groups developing each objective had to follow stringent criteria. The solutions or objectives that they sought had to be readily understood by the general public and be credible, measurable, responsible, compatible with other solutions, show continuity, and be responsive, reflecting the lessons learned in their implementation. Unlike many other health programs, the Community Health Centers program meets these criteria and in so doing will meet the challenges of the 1990s. What used to be called the United States' experiment in social medicine, the Community Health Centers program is now a 25-year-old working model that clearly meets the criteria and is tailored to the task of delivering comprehensive case-managed care.

Community health centers are unique, local initiatives that offer consumers both quality health care services and community empowerment. The community board mandate enables citizens to participate in their own decisions concerning their own health care. Of the 550 community health centers operating a network of over 2,000 practice sites in the United States today, most are private, nonprofit, community-based organizations located in high-need areas, primarily inner cities and remote rural areas. They range in size from small physician-extender practices to larger centers with over 35 physicians and 60,000 patients.

Community-Oriented Primary Care

The service delivery model of these centers is community-oriented primary care (COPC) which was developed in Israel by Sidney Karp. COPC is a community-based integrated model of partnership between patients, health care professionals, and the health care delivery system used to improve systematically the health problems of the defined population it serves. Responsive to community epidemiology gleaned through data-sharing with other community providers, COPC promotes health services and prevention relative to the real and perceived needs of the population. Because the model is community-based, it is responsive to need; because it focuses on epidemiology, it performs surveillance and is self-adjusting; because it is integrated, it creates community-based teams, reducing duplication and emphasizing continuity and the continuum of care. COPC is an inclusive, not exclusive, system.

Restructuring the Health System

If we look at the major health policy issues of the last two decades, we will not be surprised at the trends since the start of our war on poverty—the push for free enterprise and competition in the 1970s through cost containment in the 1980s. Unfortunately, with the increase in cost of health care came a decrease both in access to health care and in health status. This appalled the nation, and a call went out to restructure the health care delivery system. This restructuring has focused on how to provide health care to those not covered by public programs or by private insurance, to find an alternative responsible to the need of the medically underserved.

Although community health centers meet the criteria set forth by the Office of Disease Prevention and Health Promotion (1), this method of providing health care has not always been considered a part of mainstream medicine. Twenty years ago, urban health initiatives, rural health initiatives, and migrant health programs were developed for, and limited to, poor people. Community health services tended to work outside the established state and local systems. In the recent past, however, the population without access to health care has changed. No longer are community health center patients exclusively those living in absolute poverty. Community health services now serve a broader constituency comprised of the unemployed poor, the working population...
poor, the uninsured, the underinsured, those with catastrophic illness, and even the well-heeled and well-insured.

Recent political alternatives advanced by some of our most enlightened advocates have been episodic and categorical in nature. Our Association and the National Association of Community Health Centers urge that these alternatives be broadened to meet the challenges of the 1990s. Community health centers are predicated on primary care and have redefined "community" to include all of those who are in need. In examining that community, we will see that it also is inclusive. Our base of political support has broadened as has our base of health care need. Through the restructuring of the health care system and the development of a broader base of political support, we are presented with the opportunity for all state, local, and federally supported providers to become integrated and integral parts of a comprehensive health and human services delivery system, one which is modeled after and includes community health centers.

Will this system be more expensive? Community health centers provide primary and preventive services that have been documented as cost-effective over the long term. A wide range of studies have shown these health centers to be highly cost-effective, particularly in serving high risk populations. By stressing prevention, early intervention, and case management, community health centers have reduced costly inpatient care. Those who have studied medical economics understand that it is not competition that reduces the cost of health care but cooperation and nonduplication. These are the fundamental operative principles in community-oriented primary care.

Major studies have shown a documented improvement in health status in communities that have developed community health centers. By working compatibly with the ambient human services system, health centers have made direct arrangements with health departments, medical specialists, hospitals, and teaching institutions to provide for a comprehensive range of services for the communities they serve.

The success of community health centers in providing quality, cost-effective health care has prompted one researcher to conclude that the expansion of this community-based program is important for reducing infant mortality among minority populations within the United States. Additionally, Dr. Louis Sullivan, Secretary of the Department of Health and Human Services, has expressed a strong commitment to the development of a national health policy that will be especially sensitive to the needs of the medically underserved. He has also given his commitment to strengthening the outreach that our community health centers provide and has emphasized the need to double the number of community health services throughout the nation. Dr. Sullivan has recognized the quality of the community health center model as a vehicle to address the health care needs of the nation, as have other well-established medical, academic, legislative, and business entities.

The integrated community-oriented primary care based system forges partnerships and empowers the community. I believe this is the solution we seek for the 1990s.

Reference