Paradoxes of health care

NATHAN GLAZER

Some intriguing questions—indeed, mysteries—seem to arise when one examines the field of health care. I intend to present some data—the best available, to my knowledge—bearing on three assumptions which most people accept as unquestionably valid: (1) that we need more health personnel, particularly doctors; (2) that the poor get less health care than the non-poor; (3) that the approaches to health to be found in England and Sweden are clearly superior to our own and should serve as a model for us. I then propose to raise a more general question about the cultural differences among groups as a neglected problem in the assessment of health care.

I

One reads everywhere about shortages of doctors, nurses, hospital personnel, technicians of all kinds. One knows of endless waits in hospitals, clinics, doctor's offices. The diligent reader of Congressional hearings will find experts in every field reporting that there is a need for more training, more training facilities, for more specialists and
personnel of every kind. Thus, one Congressional committee in 1966 points out:

The Public Health Service reports that we have approximately 10,000 trained home health aides as compared to 200,000 that are needed. . . .

Or,

As long ago as 1953, it was concluded that adequate sanitation program staffing called for at least one sanitary engineer or sanitarian for each 15,000 persons. . . . A host of new areas of responsibility have been added since, but some local communities, counties and states do not meet the standards for environmental control set thirteen years ago. Over 13,000 sanitary engineers and sanitarians would be needed to meet those 1953 minimum staffing requirements. . . . Of this number, a 1962 survey concluded that between one-third and one-half are actually employed. . . .

Or,

The public spends 2.4 billion a year to maintain a standard of dental health in which only 40 per cent of the people visit a dentist even once a year.

And thus, logically, we would need at least a doubling of the 106,000 dentists and dental hygienists and technicians.

Dr. Howard Rusk makes a similar point:

President Johnson in his health message pointed out that last year we broke the record and rehabilitated 120,000 disabled persons. . . . It was 40,000 in 1945. The President's 1966 budget called for funds to rehabilitate an additional 25,000. But when you realize there is a backlog of 2,000,000 and when we get 250,000 new cases a year. . . .

Once again we have a prima facie case for doubling expenses and personnel, and this in one of the most rapidly growing programs of the government.

If we look at needs from another perspective, the shortages are even greater. Thus, if we consider those areas of the country that are best served with personnel, and those that are worst served, the differences are of the order of magnitude of two or three to one.

In 1957, three states in the northeast averaged 176 doctors per 100,000 population; three states in the southeast averaged 71 per 100,000. In metropolitan counties, the ratio was 173 per 100,000; in counties neither metropolitan nor adjacent to metropolitan counties, the ratio was 74 per 100,000. In isolated rural parts of these counties, the ratio was 50 per 100,000. There has been no substantial change in this pattern in recent years, though it has been pointed to regularly for at least forty years. In 1965, New York State had 133 physicians per 100,000 population in private practice, Georgia 70, Mississippi 60.
Isolated rural counties had less than half as many physicians as their share of the population (3.2 per cent of the population, 1.5 per cent of the doctors). Low-income sections of cities did even worse. In Watts before the start of the OEO-funded community health center, there were eight physicians for 35,000 people. The newspapers often report the plight of towns that are ready to provide doctors a house, a car, and a clinic—and get no takers. In New York State, with the best doctor-patient ratio in the country, 56 municipalities with populations of more than 2,000 have no doctor.

As for doctors, so for nurses: in 1957, Connecticut had 599 professional nurses per 100,000 population; Arkansas only 123. The northeast states, as a group, had 416 per 100,000; the east south central had 144 per 100,000. In 1963, it was estimated by the Surgeon General Consultant Group on Nursing that 850,000 more nurses would be needed by 1970—which was 100,000 more than were being used in all hospitals in 1963. And, in order to indicate that these estimates were not simple professional hyperbole, it could be pointed out that, in 1961, one-half of the positions for professional nurses in public hospitals in New York City were vacant; in hospitals in general throughout the country, the figure was 20 per cent. In 1967, three-quarters of the positions for professional nurses in New York City's municipal hospitals were vacant.

And yet—

The case is overwhelming. Between 1955 and 1965, while population increased 17 per cent, medical auxiliary personnel increased 63 per cent. That should have made a difference—but, as we have seen, by the later date there was no let-up in projected shortages for the present and the future. If we estimate shortage by some standard established by a professional group as to how much of some kind of personnel is needed, there is indeed a shortage.

If we estimate shortages on the basis of health in well-served and poorly-served areas, the matter becomes more obscure. For example, William N. Hubbard has pointed out:

In the United States the ratio of physicians to population varies from 188/100,000 in New York to 93/100,000 in Wisconsin, with little difference in the general health status of the two states. . . . During World War II there was a massive exodus of physicians from [civilian practice] in 1942, and a sudden return at the end of the war. These shifts did not affect statistical measures of trends in general health. [My italics]

And now let us observe the interesting experiment conducted by
one expert health planner, Robert M. Sigmond, the director of a leading health planning council:

During the past year I have been conducting an informal, unscientific, unstructured, confidential survey. I have presented dozens and dozens of practicing physicians with the following hypothetical suppositions and questions:

Suppose this country faced a national emergency like a long world war that required your region to contribute as many physicians, nurses and other health workers as possible. Suppose further that you were placed in charge of the health services in your region and were assured of the complete trust and cooperation of everyone. Would you be able to contribute any of the region’s physicians, surgeons, nurses and other health workers for national emergency service, without impairing the quality of the health service provided in your region?

Every single individual whom I questioned believed that if he could achieve complete cooperation and commitment, health manpower in the region could be substantially reduced without impairing quality of care and without adverse effect on the people’s health. The unanimity of response was striking.

Even more striking were these physicians’ responses with respect to the amount of reduction in health manpower that could be achieved without reducing the quality or effectiveness of service. When asked to estimate the proportion of the region’s health manpower that could be released for national emergency service, the answers varied from about 10 to 40 per cent, with an average of about 20 per cent.

Equally as striking was the conviction of most of these doctors that the greatest proportion of health manpower could be spared among the most highly trained health personnel—physicians and nurses, for example, as contrasted with aides, orderlies, and kitchen workers.

How would manpower reductions be achieved? . . . There was a surprising consistency of basic themes.

1. grouping physicians (and other practitioners) in organized settings and centralized locations so that they can make full use of lesser skilled but specially trained workers in their ‘office practices’ and thus provide more service per physician;
2. locating more physicians offices at hospitals and removing the distinction between ‘office’ and ‘clinic’ to reduce physician travel time and permit full use of the hospitals’ manpower and technical resources without having to admit patients as bed patients;
3. redefining many health service tasks so that lesser trained personnel can take them on . . . ;
4. permitting nurses to make house calls in medically supervised home health programs;
5. creating closer linkages between related hospitals to permit grouping of maternity, open heart surgery, and other specialized low use services at fewer larger hospitals;
6. encouraging all families to develop more efficient medical care habits by identifying with one nearby physician group for provision and supervision of all needed health services.
Other ideas were mentioned less frequently: automation and computation, self-help units in hospitals, intensified health education, multiphasic screening, etc. No one in the group suggested any lengthening of the work week. . . .

Interestingly enough, many of the doctors whom I asked felt that the process of reorganizing to reduce manpower could produce improved quality with fewer health personnel. . . .

I . . . asked one last question: suppose the great national crisis was not a long world war, but the spiralling cost of medical and hospital services and the many unmet health needs right in your own region, the deaths and suffering that could be avoided by expanded and improved health service. . . . Could you deliver? I wish I didn't have to report that most of my group doubted that it would be possible, under present circumstances, to achieve the degree of commitment and cooperation that would produce results. At least, as a number said, 'not in my lifetime.'

What are "reasonable" goals?

It is clear that Mr. Sigmond and his friends are not about to rush into combat to try to restrict the flow of federal funds into the medical schools, nursing schools, and other institutions which try to increase the quantity of personnel. Quite the contrary; when new legislation and new funding are proposed, they will come forward to support it, by pointing to the shortages of personnel. And they would have a reasonable argument. The reorganization of health services that might justify a reduction of personnel is not forthcoming, and in its absence we do face the reality of concrete shortages.

But in the light of such awkward evidence, one is entitled to ask: what "goals" for health personnel are "reasonable?" A few years ago, one health specialist went back many years to examine the regularly predicted shortage of doctors that was to overwhelm us in this country. He concluded that, even though we never seemed to undertake action on the scale that each study said was absolutely necessary, the shortage nevertheless did not overwhelm us. Indeed, one could argue that the extraordinary increase in doctors' fees in the last few years has not occurred because the doctor shortage finally caught up with us but because the government, through Medicare and Medicaid, guaranteed the payment of "customary" fees. As a result of these guarantees, those doctors who charged less to the aged and the poor no longer found it necessary to do so. If there had been 10 or 20 per cent more doctors, one wonders—I have no evidence for this point—whether the increase would have been moderated in any marked way. Perhaps, just as research shows that people may be
found to fill whatever number of hospital beds are provided, people will be found, if there is a guarantee of payment, to patronize whatever doctors there are.

Whenever the health specialists regularly demand more personnel (as they demand more beds), skeptical economists will point out that, for example, there are enough trained nurses not working to overcome or mitigate the calculated shortages, and that salary increases would bring them back into the nursing profession. Interestingly enough, in this case, owing to the recent organization of nurses in many areas, and the resulting increase in wages, it was possible to test the analysis. The National Advisory Commission on Health Manpower of 1967 was the first of a whole series of postwar government reports to find that the projected number of nurses would not fall too short of need or demand in 1975. It was also rather moderate on the need for an increase in the number of physicians. In short, it seems clear that the “shortage” of doctors and nurses is not simply a matter of numbers but of efficiently utilizing the numbers that now exist.

II

There is no question that the poor are sicker. Unfortunately, there are no nationwide mortality statistics by income. One of the best studies has been a recent comparison of poverty and nonpoverty areas in Chicago. (This does not permit really fine analysis, because of the limitations of area comparisons.) Crude mortality in poverty areas was only three per cent higher than in nonpoverty areas; but the people in poverty areas are younger, and if it had been possible to compute age-specific rates, the differences would be much greater. Differentials in infant mortality were very large—75 per cent higher in poverty than in nonpoverty areas. In both cases, the differences between white and nonwhite were even more substantial than between poverty and nonpoverty areas.

The clearest and best evidence of poorer health among the poor is to be found in studies of days of disability per person per year, where differences of the order of two-to-one are found. Those in families with income of under $2,000 a year have 29 restricted activity days a year, while those with family income over $4,000 a year have less than half that, 13 restricted activity days a year.

But while the poor are sicker, the differences in the utilization of health care are not as marked as one might expect. The same study which reported twice as many disability days for those under $2,000 a year as for those over $4,000 a year showed lesser differences with
respect to the use of physicians. Fifty-nine per cent of the poorer
group have consulted a physician in the previous year, 13 per cent a
specialist, compared with 73 per cent and 28 per cent of the better-off
income groups. These differences in health care utilization by poor
and nonpoor, which were once extreme, are now declining. Indeed,
in some settings they are now reversed. In 1928-31, families with an
income of more than $5,000 spent 11 times as much on medical care
as families with incomes under $1,200. In 1962, families with incomes
of more than $7,000 spent only 37 per cent more on medical care
than families with incomes under $2,000. (Between 1928 and 1962,
the proportion of the population in families with more than $7,000
in income rose from six to 31 per cent; the proportion in families with
under $2,000 fell from 55 to 12 per cent.) The cut-off points for
income in the two years are quite different, but they clearly record
a great equalization of expenditure.

The correlation between income and hospital admission has also
fallen. In the 1928 study, the admission rate for those over $10,000
a year was more than twice that for those in families between $1,200
and $2,000. A 1952-53 study showed almost no association between
income and hospital admissions. This result came about because, in
the insured portion of the population, there is a negative association
between income and hospital admission (210 admissions per 1,000 for
those in families with incomes under $2,000, 120 for those in families
with incomes over $7,500). The National Health Survey of 1957-63
shows again almost no association, with a slight bulge for middle-
income groups between $3,000 and $6,000. But, when one makes an
adjustment for the fact that the poorer families are older, there is a
slight association between income and hospital admission—117 for
those below $2,000, 128.5 for those above $7,000. The association is
nothing as large as it was in 1928-31.

New York City, which in respect to social policy often seems to
project the course that the rest of the country will follow in a few
years, gives striking evidence of the increasing equalization of health
resources among different income groups, owing to the elimination
of income barriers to the use of health resources among the poor
(that is, those on welfare, who number one-eighth of the population
of the city, and an even larger number who are eligible for a sub-
stantial range of free medical services under Medicare). Indeed, eco-
nomic barriers are now either non-existent or minor for the poor, who
thus may face fewer economic barriers to health care than most of
the nonpoor, whose insurance generally only covers part of their
health needs. Two recent studies demonstrate the substantial use
of health care services by the poor. Thus, a 1966 study of a sample of New York women and children on welfare shows the mean number of physician contacts (visit to physicians, home visits, emergency clinic and other clinic visits) is 5.0 per year for the mothers, 7.7 for the children, which the authors of the study point out is comparable to national norms. The authors compare their sample with an National Opinion Research Center survey in 1955, which shows the following number of physician visits by women, by income:

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Visits per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>under $2,000</td>
<td>5.0</td>
</tr>
<tr>
<td>$2,000 - $3,999</td>
<td>4.3</td>
</tr>
<tr>
<td>$4,000 - $6,999</td>
<td>4.5</td>
</tr>
<tr>
<td>$7,000 and over</td>
<td>4.9</td>
</tr>
<tr>
<td>all incomes</td>
<td>4.5</td>
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</tbody>
</table>

A 1964 study shows an average of 4.8 physician visits for the civilian, non-institutional population of New York City. Differences by income were reported only for those with family incomes under and over $4,000. Those under $4,000 had 6.6 physician visits per year, those over $4,000, 4.2. The comparable figures for the northeastern United States in 1963-64 still ran the other way: 4.3 for those under $4,000, 4.7 for those over $4,000. The differences by income in New York—with the poorer showing more visits—showed up for each of the major groups in the population (white, nonwhite, and Puerto Rican). The poorer remained sicker—the number of acute conditions was greater for those under $4,000.

Nationally, the statistics collected by the National Center for Health Statistics shows increasing convergence in utilization of health services—measured quantitatively—between 1958 and 1966. Income differences in utilization still exist, but they are declining. One analyst concludes: “Income level of family seems to play little part in the utilization of physician services when race, sex, age and education are considered.” Similarly, “Less and less difference continued to be the case among educational groups and whites and non-whites, although the differences remain quite significant in both instances.”

Better, worse—or different?

But more significant than the scale of remaining differences in utilization between income and racial groups are two other elements. One is the quality of medical care. We pointed earlier to the fact that the poor see specialists less often than the better-off. Another difference is found in the reasons for which care is sought. The
better-off have more preventive and diagnostic visits; the poorer have visits for acute conditions. These are clear differences, to be found in the data.

Other differences are harder to quantify but are certainly equally important. We know the poor go more often to clinics and emergency wards—but is the care better or worse than for those who go to private physicians? Whether better or worse, it has certainly been different. Perhaps one way of suggesting the difference is to reprint Oscar Lewis’s description of a visit by a poor Puerto Rican mother to a New York clinic:

Finally Soledad’s turn came. A tall Negro woman in a navy-blue uniform handed her paper jackets, saying, “Here, put these on the children.” Then she began to fill out a form for Soledad, beginning with her name and address.

“And how many children have you?”
“Four.”
“Names?”
Soledad gave the children’s names, explaining that her son, Quiquo, was in Puerto Rico with his father.

“How come this little girl’s name is Alvarado?”
“Because she isn’t my own daughter, I adopted her,” Soledad answered.

“Well, I’d better put them all down as Rios,” the woman said. “What is your husband’s name?”
“My husband is dead.”
What did he die of?”
“In an accident.” Soledad answered the woman’s questions rather sullenly. “What busybodies these people are!” she said in an aside to Rosa. “You’d think I was being jailed for murder.”

The attendant asked if Soledad was getting welfare aid. Soledad replied that she was not. “Don’t you know you qualify for it?”
“Forget it,” Soledad said shortly. “As long as I can work to support my children, I don’t want welfare. Not the way they treat you.”

“Have the children been in contact with anyone who had tuberculosis?” the woman asked.

“Well, yes, with a cousin of mine in Puerto Rico a long time ago. But it was the school doctor who told me to bring the children here.” The attendant went out and a doctor came to give the children the tuberculin test. He then sent them to an adjoining room for chest X-rays, telling them to come back for the results a week later, on Friday.

Before they left the Health Bureau, Soledad spoke to the attendant who had filled out their forms. “Could you take care of my nephew? All he needs is to have these stitches cut.”

“No, not here,” the woman answered. “You’ll have to take him to a hospital for that.”

“But we can pay,” Soledad said.
No, we can't do it here,” the woman repeated impatiently, waving them out.

“What sons of the great where they are, all of them! They should have a bomb dropped on them,” Soledad exclaimed. “Look,” she said when they were outside, “I’m going to cut Gabi’s stitches myself. I know they won’t do it at the hospital either. They don’t want to take care of him.”

This is not a particularly horrendous example of the treatment of the poor, but suggests its disjointed and often indifferent character. A hypothetical description by Lester Breslow is even more vivid:

Consider the case of a young woman whose family is receiving Aid to Families with Dependent Children. The most likely medical event in the life of such a woman is pregnancy. Assuming that she is a highly intelligent and well-motivated woman, she will seek prenatal care as soon as she finds that she may be pregnant. She seeks this care from her local health department clinic. When the time comes for her to deliver the baby, she is transferred (theoretically with her records but in actuality most likely not) to a public hospital. There she encounters a new set of documents and personnel for delivery of the baby. Before discharge, the baby will be examined by a pediatrician who will never see the child again. Now this highly intelligent, well-motivated young woman will take her baby to a well-child clinic operated again by her health department but at a different place from where she received her prenatal care and at a different time. After several such visits to the well-child clinic, the baby may become ill. When the mother takes the baby to the clinic where the doctors and the nurses have been providing care, she is informed that she cannot obtain care there any longer because the child is sick. She is advised to take the child to a physician near her home who is paid by the welfare department. This new physician establishes still another record for the baby and provides care in his office. If the child becomes sick enough to require hospitalization, the physician tells the mother that he is not able to admit her child to the hospital where he practices because she is on welfare and she must take the baby back to the public hospital. She turns again to the public hospital care for her sick child, but after a few days is informed that the child has a special condition making the baby eligible for crippled children’s services, which must be provided in still another resource. . . .

It is a depressing picture, and suggests the need for better organization of medical care for the poor, rather than simply a greater quantity of health resources. But when we speculate just what that organization should be, there is no clear answer, as we may see by considering the health care systems of other countries.

Our concern with the health care systems of other advanced countries has stemmed from three sources. First, they provide care at far lower costs than we do. Second, there is much less discontent with the health care system. And third, they not only provide cheaper
care, and more satisfying care; the consumers of this health care also show up as healthier than Americans on the major indices.

The most important such index for international comparisons has been infant mortality. And all through the 1960’s there has been considerable concern at the poor American performance in this respect. In 1963, against a United States infant mortality rate of 26.0, Sweden showed a rate of only 16.6, and Australia, Denmark, England, and Wales, Finland, the Netherlands, New Zealand, Norway, and Switzerland, all showed lower rates. Later in the decade, the United States stood 24th in international comparisons—most of the industrially-developed nations of the world now did better than this nation. Nor did we do better with adult mortality. In 1959-61, every nation in the OECD but one showed a lower death-rate for males in the ages 45-54 than the United States, all but three showed a lower death rate for females, seven showed lower infant mortality rates, ten showed lower mortality rates over-all.

But, let us now consider Sweden and England more closely.¹ We will note, first, that, even if the AMA is now convinced, along with almost everyone else, that we need more doctors, the fact is that we already have considerably more than England, and far more than Sweden. The United States, in 1958, had 140 doctors per 100,000 population, England and Wales 111, Sweden only 83. Perhaps the Swedish doctor works very hard and gets to see many patients? Not so if we estimate work-load by number of patients seen. In Sweden, the average number of visits to the doctor per person per year is 2.5, compared to 4.7 in England and Wales and 5.3 in the United States. On the other hand, the Swede goes to the hospital much more often than the Englishman, slightly more often than the American. The range in hospital use in the three countries is given in the following table:

<table>
<thead>
<tr>
<th>Table 1. Hospital Admission Rates Per 100 Population</th>
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<tr>
<td><strong>BEDS PER 100</strong></td>
</tr>
<tr>
<td><strong>POPULATION</strong></td>
</tr>
<tr>
<td>England and Wales</td>
</tr>
<tr>
<td>Sweden</td>
</tr>
<tr>
<td>United States</td>
</tr>
</tbody>
</table>

If we think that the Swede is going to the hospital more often for minor ailments, and getting better care for them, this assumption is challenged by the fact that his hospital stay is much longer than the

¹This section is based on important comparative work by Osler Peterson and Odin Anderson.
American's—15 days (as is also true in England), compared to eight here. It's doubtful that many Swedes spend 15 days in a hospital for a minor ailment—hospitals are still just hospitals, not country clubs.

So the Swedes see doctors less, use hospitals more. There are also remarkable differences in the use of hospital personnel. Odin Anderson estimates that, while Sweden has one employee per hospital bed, the United States has two and one-half.

We all know we shall have to spend more for medical care—every study so assures us. Yet, in comparisons made 10 years ago Sweden spent 3.5 per cent of GNP, compared with 5.3 per cent in the United States; yet its infant mortality rate was 63 per cent of that of the United States, and its mortality rate for males aged 45-54 was only 52 per cent of that of the United States. (England spent a higher proportion of GNP—4.5 per cent—than Sweden, though still less than the United States, and did better than the United States, though not as well as Sweden; its infant mortality rate was 87 per cent of ours, its male mortality rate—45 to 54—76 per cent of ours.) What does one conclude from such a comparison? That we need fewer doctors, fewer nurses, and more hospitals? Certainly, that would be one cheap way of making the United States, in some respects, more like Sweden.

Of course, the more reasonable conclusion is that the critical issue is not the quantity of health facilities or of health manpower, but the system of organization of health care. Yet having said that, we still have some problems. It is interesting that no one in this country, whether on the left or the right in issues of health care, proposes following what seems to be one of the most striking features of the system of health care in England and Sweden—the sharp separation between the general practitioner and the hospital physician. The hospital physician works full-time in a hospital; when patients are referred, the general practitioner gives up all claim to care, and the patient is now in the hands of the hospital staff. This means a sharp differentiation in status, and it means too that those opportunities for education and control of the physician treating his patient in a hospital under hospital rules that our system at least makes possible do not exist in those countries. The change most widely proposed in American health care—comprehensive care by a team of physicians and other professionals—is not at all common in England and Sweden, where the doctor is still the primary source of health care for people.

III

The elements of the English and Swedish system that we can most easily follow are those of universality of access to a common system
and better provision of care in distant and rural areas. While simple
decency requires that we move in that direction, we should not over-
sell the results in advance. One cannot help feeling, reviewing the
amazing pattern of hospital understaffing—by our standards—in
Sweden, that a good deal must be based on the fact that there are
Swedes in the hospital, and Swedes serving them. In other words,
there are aspects of culture that affect health and care, and these
aspects may be quite independent of the health care system.

There is a good deal of evidence along these lines. Even in this
country, there are substantial differences in health which seem quite
independent of differences in health care systems. Consider the differ-
ences between states of the United States, all with about the same kind
of health care system:

The most important differential [in mortality] is race, but even con-
sidering the rates for whites only, the age-adjusted death rate (aver-
age 1959-61) in the highest state is 33 per cent greater than in the
lowest; and the highest infant mortality rate is 55 per cent above the
lowest; and the death rate for males 45-54 in the worst state is 60 per
cent higher than in the state with the lowest rate.

And the variation between the states is not to be explained only by
the resources they devote to medical care. In 1954-57, Utah and Iowa
had the lowest infant mortality rates in the country, and they had by
no means the largest input of resources. (Indeed, if one wants to push
this further, it may well be the states with the highest proportion of
Scandinavians who seem to do best in health.)

We can point to two major factors which help explain why the pro-
vision of health care, even when well organized, may be only in-
differently related to the improvement of health. The first is the role
of still poorly understood cultural factors in affecting health, inde-
pendently of available health resources and the health care system.
Thus, there are remarkable differences between different ethnic and
racial groups in health, even when we hold constant the amount of
health care available to these groups.

Table 2. Perinatal mortality rates for New York City, 1961-3.

<table>
<thead>
<tr>
<th>FATHER’S OCCUPATION</th>
<th>WHITE</th>
<th>NEGRO</th>
<th>PUERTO RICAN</th>
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</thead>
<tbody>
<tr>
<td>Professional Managerial, and Technical</td>
<td>16.7</td>
<td>24.2</td>
<td>22.5</td>
</tr>
<tr>
<td>Clerical and Sales</td>
<td>20.8</td>
<td>31.5</td>
<td>24.4</td>
</tr>
<tr>
<td>Craftsmen and Operatives</td>
<td>20.9</td>
<td>32.9</td>
<td>24.3</td>
</tr>
<tr>
<td>Laborers and Service Workers</td>
<td>25.9</td>
<td>36.6</td>
<td>27.8</td>
</tr>
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This is easy to illustrate. If we consider Negroes and Puerto Ricans in New York City, for example, and we hold constant the socio-economic background of parents, we find startling differences in infant mortality, as Alonzo Yerby has indicated in the table above.

Lester Breslow has pointed to the surprisingly better health records for Japanese and Chinese in California where the infant mortality rates for 1964 were: 33.9 for Negroes, 20.8 for Caucasians, 13.6 for other nonwhites. And, in the case of the five-year relative survival rate from localized cancer of the breast: 73.4 for Negroes, 81.5 for Caucasians, 90.8 for Japanese.

Minako Kurokawa has studied the remarkably low childhood accident rates of Japanese in California. Odin Anderson has pointed to the evidence that immigrant Jews, despite extreme poverty and overcrowding, showed a remarkably low rate of infant mortality. Comparisons in eight cities in the period of 1911-16 showed that while the white rate averaged 108, the native born white 94, and the foreign-born white 127, the foreign-born Jewish rate was an incredibly low 54.

Culture, operating through socio-psychological factors, is thus clearly one element determining the health of a population. To unravel its influence is enormously difficult; and to then go on from that to health care policies that will take these influences into account is even more difficult. Again, in countries of homogeneous population, these effects of culture on health are constant, or near constant—the health system takes them into account automatically, so to speak. In a country with a population of varied origins and distinct subcultures, the problem is not so simple.

One of the reasons these subtle socio-psychological differences between subcultural groups continue to have consequences for health is that, as some major traditional causes of disease and death are conquered, personal and psychological factors become important in determining an individual's capacity to maintain health. Thus, Odin Anderson points out in connection with infant mortality:

Once the [infant mortality] rate drops down to 30, the broad economic and social factors operate with lessening effect, and personal behavior factors of the families in the high impact mortality groups involved, particularly the mothers, begin to exercise an increasingly dominant influence.

And, Dr. Alfred Yankauer writes, in connection with child health care services:

One must recognize, however, that not all countries seem convinced of the values of integrated services. The Netherlands and Sweden,
which boast the lowest infant mortality rates in the world, seem content with the current separation of their preventive and curative services. One wonders whether this is a reflection of their small populations, homogeneous nation cultures, common values and traditions. These might serve to promote an informal communication and basic understanding which in a large, complex, heterogeneous, mobile society such as the United States must be formalized through administrative and institutional channels.

There is a second line of argument and investigation which weakens the connection between health achievements and a specific health care system. This is the growing weight of evidence that general environmental conditions, which seem to have played a large but undetermined role in reducing the death rate in the 19th and early 20th centuries, may now be playing a substantial role in increasing it in the latter third of the 20th century. Thus, Victor Fuchs writes:

One of the factors contributing to the difficulty of reaching firm conclusions about the relationship between health services and health is the importance of environmental factors. Some . . . are biological, involving the appearance and disappearance of bacteria, viruses, and other sources of disease. Some are tied to the production process, e.g., the factors associated with occupation. Others are part of consumption, e.g., diet, recreation. Major attention has been given to income, partly because many other environmental factors tend to be highly correlated with real income, both over time and cross-sectionally. Examples include housing, education, urbanization, drinking and the use of automobiles.

The prevailing assumption, in some cases with good evidence, has indicated that an increase in real per capita income has favorable assumptions for health, apart from the fact that it permits an increase in health services. This assumption for the United States at present, except for infant mortality, may reasonably be questioned. This country may have passed the peak with respect to the favorable impact of a rising level of living on health. [My italics]

For two reasons then, even when we adopt some of the measures that we know will improve our chaotic and frustrating methods of providing health care, we may not do as well as countries that are smaller and poorer. One might conclude with two passages, one from the pediatrician Alfred Yankauer, one from the economist Victor Fuchs. They suggest some of the lines of thought, and the new directions, we are likely to be following in the future.

The contribution of the traditional personal health services to any measurable improvement of mortality indices may be sharply questioned. It may, in fact, be thoroughly irrational to justify or "sell" a child health care program solely on the basis of its effect upon indices of mortality and morbidity. A more compelling basis is simple com-
passion and the ideology of service which the professional physician is expected to possess. It is no longer tolerable that the food, or the quantity, quality, and personalized nature of the health care which an infant receives, should be determined by the income and race of his parents.

Victor Fuchs says:

My final suggestion—almost plea—is for us to remember that what we are really concerned with is health—not costs as such, and not medical care as such. My reading of the health literature leaves me with the impression that the greatest potential for improving the health of the American people is not to be found in increasing the number of physicians, or in forcing them into groups, or even in increasing hospital productivity, but is to be found in what people do and don't do, to and for themselves. With so much attention given to medical care, and so little to health education and individual responsibility for personal health, we run the danger of pandering to the understanding urge to buy a quick solution to a difficult problem. [My italics]

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