ACUTE AND CHRONIC ILLNESS

E. D. Pellegrino, M.D.

THE MACY FOUNDATION CONFERENCE: THE GREATER MEDICAL PROFESSION
SECTION: THE DELIVERY OF MEDICAL CARE--BY WHOM?

London, England
June 14-15, 1972
INTRODUCTION

American medicine today has the capability, and American society the resources, to make a full measure of health available to all our citizens. The expenditure of seventy-five billion dollars annually and the employment of four million health workers attest to our interest in achieving this end. What is lacking, however, is a clear matching of this massive endeavor with the common and universal medical needs of the population.

At this point, our health care system resembles a huge renegade planet launched upon a trajectory taking it ever further from the sources of its creation. This trajectory seems bent to the autonomous needs of the system and away from the satisfaction of two large, vital, and essential needs: a recognizable, efficient, and sensitive mechanism for primary contact with health services when a new medical event occurs, and a mechanism for continuing effective contact when long-term disease and disability have established themselves.

There is no recognizable pattern for the flow, no distribution of health workers and institutions, and no clear assignment of functions specifically ordained to meet these two pressing needs. The national burden of ordinary acute and chronic illness must be met fortuitously, if at all, for too many
of our people. Therein lies the much publicized crisis of health care: the mismatch between what the public perceives as its interests and what the health professions provide to serve that interest.

My task is to examine this mismatch in terms of who can, and should, eliminate it. My thesis can be stated simply: we cannot hope to resolve the twin dilemmas of fulfilling the capabilities of modern medicine and making it available as a civil right by any simple arithmetic extrapolation of the number of physicians or by the present mode of assignment of functions among health manpower and institutions. Instead, we must address the more vexatious task of redeploying all existing and future manpower along functional lines more congruent than is now the case with the bulk of needs perceived by society.

Lacking this redeployment, we can expect, in the United States at least, the generation of an alternate system of services and education outside existing modes. The public mood of disappointment and anger will not long tolerate such glaring deficiencies as now exist without seeking viable alternatives, even at the expense of dismantling some of the best parts of the existing system. Rather than creating the "Greater Medical Profession" for which this conference hopes, we may face the creation of a "lesser medical profession," one imposed by a desperate and disappointed public seeking satisfaction of its needs by the next best means at hand.

Clearly, the runaway health care planet must be recaptured. Its orbit must be perturbed to conform more closely to the pull of the central mass of mundane and universal needs of the majority of us when we are acutely or chronically
ill. For, it is out of those central reeds that the whole system derives its raison d'être.

ACUTE MEDICAL CARE: THE NEED FOR PRIMARY CARE

By all odds, the major unmet need in acute care in the United States today is universal availability of a satisfactory means of primary and first-contact care. When a person becomes ill—and this must be by his own definition of not feeling well—he needs the means for easy, efficient contact with some representative of the health care apparatus who can take responsibility from the patient and relieve him of the anxiety for determining whether the situation is serious or simple, advise on what the next steps should be, arrange for those steps to occur—simple measures provided in situ—and the more complex situations detected and referred. The patient wants to be assured also that the advice is competent and that the full resources of the entire system are available if required. All of us have a right to expect these needs to be met in every community, twenty-four hours a day, every day of the week. Moreover, these first-contact services must be provided at some reasonable cost, courteously, and without regard to race or ethnic or socioeconomic considerations.

It is precisely these first steps in acute illness that are insufficiently available, despite our thousands of hospitals, clinics, health agencies, and health manpower. There is no dearth of surgeons willing to excise one's gallbladder, of internists eager to distinguish between polyarteritis and lupus, or of ophthalmologists to excise our cataracts. What we lack are
people who will respond to an unscheduled call for help for an uncategorized disorder at an ill-timed hour of the day.

The deficiency is severest in rural and urban areas, but it is also increasingly apparent in suburbia on certain days of the week, on weekends, and at night. The anxiety and frustration arising from this root deficiency is at the base of much of the disquietude of Americans with their health care apparatus. It is the source of desperate measures, by consumer groups and legislators, that will surely eventuate in alternate systems of care unless the deficiency is ameliorated.

In America, the public dissatisfaction with first-contact care is of long standing and well documented.\textsuperscript{1-4} Beginning in 1932 with the report of the Committee on Costs of Medical Care, a common theme extends through a spate of reports on the "crises" in health care. Surprise, disappointment, and even anger are expressed clearly that in a country possessing our technology, resources, and organizational know-how, primary care is not provided in quantity or quality acceptable to the consumer. In 1968, the National Advisory Commission on Health Manpower pinpointed the major complaints of consumers: long delays in obtaining appointments for routine care, long waits in the doctor's office, followed by hurried or disinterested care, and difficulty in getting a physician at night and on weekends. These same deficiencies are repeated with mounting irritation in the recent report of the Citizens Board of Inquiry and the Urban Coalition's report provocatively entitled, "Rx for Action."\textsuperscript{5, 6}

The causes of this unfortunate state of affairs are multiple but reasonably
well established: 1) a decrease by one-third since 1950 in the number of general practitioners; 2) the move to specialization accompanied by more limited work hours for physicians and increasing numbers in teaching, research, administration; and fulltime institutional practice; 3) mass migration of physicians from country and city to the more attractive realms of suburbia. The net effect has been to diminish the number of physicians available for direct patient care, despite an increase in the number of physicians, exceeding the rate of growth of the population.

Multiple solutions have been proposed. The more impetuous critics favor the immediate transformation of the entire health care system by the institution of governmental controls over the types, numbers, and locations of physicians, the abolition of the fee-for-service system, and the imposition of penalties and incentives to force better distribution of health care personnel. Others favor turning the responsibility for primary care over to independently licensed physician's assistants, nurses, pharmacists, and others. The more moderate and more widely pressed solutions focus generally on increasing the production of health manpower, particularly general practitioners. To this end, many states have legislated departments of family medicine in their state medical schools, or have legitimated the physician's assistant, or reexamined their medical practice acts to permit a wider range of functions by all health professionals.

The most frequently expressed hope is that we can produce enough primary care physicians by expanding enrollments in our medical schools. Schonfeld and his associates have pointed to the futility of this approach. They have
recently estimated that we have now about half the number of physicians re­quired to provide high quality primary care for acute and chronic illness. They came to the distressing conclusion that "... there is little likeli­hood that primary care of good quality and reasonable adequacy by professional standards can be available to the population as a whole in the discernible future." We must allow for some overestimates in this study, which was based on the assessments of pediatricians and internists. Nonetheless, the results are disconcerting. Even if we could double the output of our medical schools, there is no assurance that the proportion of graduates entering primary care would increase, or that they would distribute themselves in regions with the greatest needs in primary care. The conclusion seems clear: We shall have to look for viable alternatives to the simple increment in medical school enrollments if the unmet needs for primary care are to be filled satisfac­torily in the foreseeable future.

The more reasonable alternative is to make the physicians we now have available to more people by reassigning many of their functions to other health professionals. This can be accomplished by extending the roles and respon­sibilities of existing health professionals. Then, if necessary, new cate­gories of health professionals can be developed specifically to meet the remaining unfilled needs. The most likely candidates for such role extension into the field of primary care are the nurse, the pharmacist, and the emerging category of physician's assistant.

These professionals can, as is being demonstrated in many new programs, under­take initial assessment of a patient's presenting problem and perform a
triage function. They can treat the simpler ills of mankind, like the upper respiratory infections, which constitute about one-third of the days of restricted activity experienced each year in our country. Well-baby care, preventive health care and health education, management of minor trauma, emergency care for serious trauma, and normal obstetrics comprise some of the other functions already assumed, under supervision, by nonphysicians in a variety of new programs. The range of possible assignable functions is wide, indeed, as Seldel's recent study of the functions of the Russian feldsher clearly demonstrates. 8

In point of fact, if some essential principles are observed, there are very few of the physician's functions in primary care that cannot be delegated to other members of the health care team. However, to assure safety for the patient and competency, those who thus assist the physician must operate under several specific conditions.

We must emphasize that the essential feature of primary care, as we have defined it above, is to make a prudent decision about what action should be taken immediately and what action optimizes the patient's management and minimizes the dangers. This does not ordinarily require knowledge of the specific diagnosis, but rather consists in a series of decision-making steps geared to the major facets of the clinical situation. This decision-making pattern becomes the "program." One can envision a series of programs to guide decision making for a large variety of the commoner ills of mankind, such as upper respiratory infections, headache, fever, cough, chest and abdominal pains, and so forth.
Those who assist the physician must, as a first requirement, be "programmed" to follow an agreed upon pattern of prudent decisions following first contact with the patient. The scope of the assistant's functions will thus be specifically delimited, and the procedures he may perform carefully prescribed. When the program does not "fit" the clinical situation, the assistant must consult the physician or other health professional possessing the next level of clinical sophistication.

This means, as a second requirement, that the assistant must function under the direct or indirect supervision of a primary care physician. In more remote areas, this will necessitate the use of technology for efficient voice and image communication, a readily accessible means of rapid transportation, and a problem-oriented method of data recording. Especially at distant locations, computer storage of programs would be a useful means of checking and double-checking a decision-making pattern or of determining the lack of a "fit" between the clinical context and the prescribed program.

As a third requirement, the assistant in primary care and the primary care physician himself must be integrated into an articulated system of primary, secondary, and tertiary care. In this way, appropriate back-up facilities, techniques, and personnel are available at short notice when the first-contact situation demands more complicated levels of care. This is an especially important point, as Seidel's observations of the Russian feldsher indicate. The feldsher's early decisions were a major concern of the Russian physicians, who wished to assure that early diagnosis of more serious and treatable disorders was not compromised.
With such an articulation of functions, however, a system of primary care could be developed to cover most of the nation. Primary care centers, designed to meet the patient's first-contact needs, as defined earlier, could be established for defined populations throughout the country. For sparsely settled areas, greater distances between the patient and the primary care centers are tolerable if voice and image communications and transportation are assured. For more densely populated areas, the centers would be closer together. What is important in all situations, however, is that a clearly defined population be designated, each primary care center be assigned responsibility for that whole population, and the people served know where the center is located and what it does.

We may envision two types of staffing to provide twenty-four-hour per day coverage every day of the week. In the more populous regions, three or four primary care physicians could rotate duty hours among themselves, supervising a variable number of physician's assistants, depending upon the size and needs of the population covered. In the more remote regions, a group of physician's assistants could staff the primary care center themselves and be supervised via two-way radio and television by primary care physicians at a community hospital or some other distant facility.

Under the safety requirements defined above, the assistants would provide care for the majority of minor medical and surgical ills, quickly separate those who need more complicated care, and arrange for their transfer or further study. Normal obstetrics, well-baby care, and organized health maintenance programs could also be administered to the defined populations
What of the physician's role in this sort of arrangement for primary care? Optimal use of his knowledge and skill would lie in programming the assistants, coordinating their functions, providing consultation when the program does not "fit," and being available for the patient who needs further reassurance or more advanced study of his problem. The physician would possess the most sophisticated skills in primary care decision making. His intellectual efforts would be concentrated on the process of making prudent decisions in the acute clinical context, when all the data are not available or are unreliable or unverified. Diagnosis, that is to say, final closure on the name-designation of a disease entity, would not be necessary except in the simpler cases.

The physician would also be required to know when to change the program of management and to determine when a new drug or treatment is sufficiently well authenticated to be introduced into the routine program. He will rely on his ready access to the community hospital and university center for consultation in the complicated acute situations. Presumably, he would have more time for dealing with the more complex psychosocial factors facing families and individuals in the presence of acute illness.

The physician's skills would be focused, therefore, on coordination and management of his assistants and of the clinical situation. He would be expected to assess the efficiency, effectiveness, and scientific quality of the care delivered by his team of physicians and assistants. He would also
be expected to maintain liaison with those patients who have been hospitalized, visiting them when geography permits. Maintenance of the continuity of care between the primary, secondary, and tertiary care levels would also be his responsibility.

These are somewhat different functions than those which arise now in our minds when we speak of the family physician. They are, perhaps, more realistic and more attuned to meeting the large volume of primary care needs than are the fond hopes of resuscitating the all-purpose general practitioner of a romanticized past in which the demands, needs, and expectations of patients were different.

We do not now educate physicians specifically for such roles in the coordination of primary health care. The establishment of academic departments of family medicine is a very recent phenomenon. While it is an important step, even more important is the willingness of medical educators to train physicians specifically for primary health care functions, and in a way responsive to the newer patterns of organization of medical care. The demand for family physicians is largely a demand for better primary health care services. The field of family medicine will require modification in the future to keep pace with the institutionalization, regionalization, and organization of the total health care system.

Some of the nonphysician manpower to staff primary care centers can come from extending the functions of existing health professions. Nurses have for a long time carried out some of the primary care functions we have described above. The public health and visiting nurses have done so in less acute disorders,
while the coronary care nurse and the pediatric nurse practitioners have demonstrated their capabilities in various segments of acute medical care. This is true also for family care, as the several Family Nurse Practitioner Programs (Primex) have demonstrated. Further extensions of the nurse's role are sure to occur.\textsuperscript{14}

Pharmacists have served as the point of first contact on an informal basis for a long time, but in the United States their full potentialities for fulfilling these functions are yet to be explored.

It is not yet clear how many of our existing health professionals will wish to extend their functions to include primary care. They must face the question of who would fill the vacuum left behind if appreciable numbers of nurses and pharmacists were to move out of their present roles. For these reasons, the assistant to the primary care physician is being developed de novo as an allied health function. Already, the American Medical Association has approved Essentials for Accredited Programs. A growing number of educational programs is being introduced in junior and senior colleges and health sciences centers to train assistants for these roles.

The final answer to the question of who should provide such care is difficult to determine at present. Some combination of primary care physicians and physician's assistants, working in the relationship we have described, seems inevitable if we are to meet the need in any reasonable time. The assistants will more than likely be drawn from two major sources: those nurses who wish to use their basic training in this way, and physician's assistants specifically educated for the functions we have outlined. Pharmacists may enter
this manpower pool, but they will increasingly face the pull to alternative roles for pharmacy in drug information centers and in hospital pharmacy and institutional drug management.

Depending upon the characteristics and location of the populations to be served, some segmentation of functions among the physician’s assistants may be necessary. Some assistants in the larger centers might concentrate on acute medical and surgical care, others on maternal and child health, and still others on mental health. There are many unanswered questions on this score. Until they are settled, the training of physician’s assistants will remain in an uncertain state.

For optimal effectiveness and accessibility, the physicians and their assistants in the primary care centers will probably need to be complemented by a cadre of neighborhood health advisors. These persons would be ordinary members of the community trained to act as ombudsmen and advocates for the consumer. They would be familiar with the workings of the system and be available for immediate contact whenever a medical need occurred. These advisors would not provide primary care themselves but would know how to facilitate their neighbors’ access to acute as well as preventive medical services.

Our British colleagues will detect many points of similar concern in what I have described. As long as fifty-two years ago, Lord Dawson of Penn outlined a schema for primary and comprehensive care with many of these features incorporated in it. The elements of such a system are beginning to emerge in the United States, but in a fragmentary and uncoordinated manner. We have yet
to organize such a system for the entire nation, to define the functions of each category of manpower within that system, and to deploy our manpower in conformity with those functions. It is more our habit to await the fortuitous coalescence of health professionals into "teams" for this purpose.

**CHRONIC ILLNESS: FUNCTIONAL NEED FOR PRIMARY RESPONSIBILITY**

I have thus far concentrated on one facet of acute illness—primary care—because it is the most painfully felt deficiency in our American health care system, but also because it enabled me to illustrate the principles of solutions to other types of medical care as well—namely, a team approach based in a functional analysis of patient needs combined with the education and deployment of existing and new health professionals to meet those needs in an organized way.

Chronic illness further exemplifies these principles. The burden of chronic illness and disability in the United States is considerable. The National Health Interview Survey showed ninety-six million people reporting some chronic illness, twenty-one million with some limitation of activity, and six million with some limitation of mobility. Among children, the Children's Bureau estimates that twenty to forty per cent have one or more chronic conditions, of which Richmond estimates one-third could be prevented by competent care prior to age six. Like primary care, the chronic dimensions of illness have not received organized attention based on functional needs.

The essential functional deficiency in chronic illness is for someone to take primary responsibility for the patient's continuing care. The emphasis is on
continuity of responsibility, since chronic illness, by definition, has a long temporal span and is amenable to amelioration but not to definitive cure. The patient needs, therefore, an assessment of the totality of his medical problems together with their accompanying disabilities and the development of a plan for management and follow-up over an extended time period. Where cure is not a realistic goal, the patient needs amelioration of discomfort and functional loss. The chronically ill patient must also understand his disease thoroughly, so he can cope with its major challenge: to develop a mode of life that allows maximal performance within the constraints imposed by the illness. In addition, the patient with a chronic illness, like all other persons, needs ready access to the health care system whenever he faces acute episodes of his chronic disorder or a new disease.

These functional needs are rarely met in a comprehensive and acceptable manner in today's health care systems. Chronic illness is usually treated in fragmentary fashion, often grudgingly, by physicians interested in the more dramatic and more rewarding acute episodic illness. Chronic care services are even more difficult to get among deprived populations than primary care for acute illness. The needs for comfort and easing of disabilities are too easily ignored in favor of control of the "disease." The resultant deficiencies in care of the old and the chronically ill are being expressed more vociferously. These deficiencies are less dramatic in immediate consequences and too often are ignored in the face of the more immediate needs of the acutely ill patient.

Schonfeld's study also demonstrates the virtual impossibility of producing
enough physicians to meet the needs for chronic care in either children or adults. Again, we are forced to alternate methods. Chronic illness is especially susceptible to team care and to direct employment of other health professions in functions formerly the sole province of the physician. The slower pace of chronic illness, its multiple dimensions, and greater complexity suit it ideally for the team approach. The physician and his colleagues can agree upon a general plan of management, and tasks within a long-range plan can be assigned among team members. The needed services can, I believe, be provided in the main by extending the roles of physician's assistants, nurses, pharmacists, physical therapists, and others. Once the drug, diet, exercise plan for management of chronic hypertension, arthritis, stroke, or heart failure is established, the collection of base line data by physical examination and history taking can be assembled by the physician's assistants. Changes in the regimen can be made according to a prearranged plan. The physician is contacted when the program does not fit the clinical situation.

As in acute care, the physician is called upon for more skill than usual in coordinating other health personnel, establishing a clear program of management, conferring on unexpected turns in the clinical course, and checking new physical signs or new symptoms that might alter the problem list or the management plan for each problem. The physician's preeminence will be based upon greater capacities for analysis of signs and symptoms, a larger capacity for synthesis of clinical findings. The more direct, repetitive clinical observations will be made by others, as will treatment of the recurrent simpler complaints like insomnia, constipation, pain, and so forth.
Also, as in the plan for acute illness, those who assume the physician's functions must be programmed clearly, must be under supervision, and must be part of an integrated matrix of care with hospital and laboratory back-up and ready access to consultants. With such an arrangement, the knowledge and skills of the entire health care team can be optimally utilized to meet the wide variety of personal and technical needs exhibited by the chronically ill. Without it, we can anticipate only a deepening of the total crisis in health care delivery.

TOWARD A GREATER MEDICAL PROFESSION: SOME OBSTACLES

It is becoming daily more clear that we cannot meet the functional needs of our citizens for either acute or chronic care without a drastic reappraisal of the current and future roles of all health professionals. Before we further encourage unrestrained proliferation of the allied health professions, we must learn how to use the full potentialities of the four million existing health professionals in the United States. We do urgently need to evolve into a Greater Medical Profession, as the title of this symposium suggests—a single profession dedicated wholeheartedly to making available to all our citizens the fullest measure of health our society can provide.

There are vast and difficult methodologic problems essential for any effort at optimal redeployment of health personnel, and these must not be minimized. Methodologies are just being developed to analyze tasks of health workers, develop skill scales, and group these into functional and educational hierarchies. Such work has been accomplished for some twelve occupations in ambulatory care in the Health Services Mobility study recently completed in...
New York and for many more occupations in the study of the United States Navy's allied health professionals by Technomics Inc.\textsuperscript{18, 19} It is out of these studies that ladders and lattices can be established, education and delivery more closely meshed, and job mobility made a reality. The technical problems, while complex, are perhaps more easily soluble than changing human behavior and, especially, professional behavior.

There is no doubt that serious alterations of professional organization, economics, technology, and ethics are required. But, the central issue lies in the sensitive region of attitudinal and behavioral changes. The health care team is still a rudimentary and largely disordered band. As a consequence, the patient is besieged by an increasingly eager and ever larger agglomerate of professionals and technicians caught in the dilemma of trying to help while simultaneously trying to preserve individual status and roles. If volume medical care is to be delivered with some semblance of quality and with consideration, the questions of who does what and by whose order or agreement must be resolved consciously and not left to happenstance, as is now the case.

Were we able to surmount the defensive reactions of each of our professions, we could devise a rational system of care, starting with the functional needs of patients and society, then proceeding to a fresh reassignment of these functions among existing members of the health care team, without being limited by who carries them out now.\textsuperscript{20} Only when this is done should we think of new health professions. In this way, the whole process of care can be ordained to satisfaction of the unmet needs in acute and chronic illness in terms more
congruent with the expectations of society. Our emphasis has been, of necessity, on acute and chronic care. Obviously, no viable or satisfactory system is conceivable without the closest articulation between all segments of care: prevention, maintenance, and care of mental illness. The same principles of cooperative delivery apply to all segments of the health care spectrum.

There are significant attitudinal impediments to attainment of the goal of a Greater Medical Profession. Surely, the gravest threat and the responsibility focus on the functions of the physician. Doctors have always employed others to assist them in a variety of ways. But, never in its history has medicine dealt with a total and systematic allocation to others of many of its most cherished functions in patient care. Moreover, to be effective, this reallocation must be accomplished by cooperative efforts and agreement among the several health professions involved.

The consequences for the physician's future role and relationships with other health professions are profound. The idea of a Greater Health Profession will challenge the physician's role as team leader. The physician understandably is confused, anxious, and tempted to reaffirm traditional prerogatives. If computers take over some of his mental operations and other health professionals his manipulative operations, what, indeed, is a physician? The challenge of a new definition divergent in function and style from today's is a stiff and uncomfortable one, to be sure. We will no longer be permitted to define medicine by the manipulations it performs. Medicine's cognitive, analytic, and synthetic capabilities will have to be sharpened to justify its claim to preeminence. The sharing of medicine's traditional responsibilities will open up new possibilities, which must be based in more sophisticated
professional and technical skills. A professional species incapable of continuing adaptation faces extinction. I have too much confidence in the hardiness of homo medicus to fear that eventuality.

As physician's assistants, nurses, and others extend their functions in acute and chronic care, physicians themselves will tend to fall into two general categories: the organ system specialists, and the generalist primary care physicians. It is the latter who will be educated specifically for supervisory and coordinating roles in family and first-contact medicine and for parallel roles in hospital care as well. A cadre of such physicians, specialists in primary and long-term care, may well emerge out of current trends to establish family practice departments in medical schools in the United States. To achieve this end requires some clarification of the notion of family medicine to bring it into closer conformity with what the public needs and wants. 12, 13

While the physician will have more difficulty becoming part of a Greater Medical Profession, we must not underestimate the problems for the other health professions, notably nursing, which in the United States is achieving a larger measure of professional independence. Nurses do not necessarily see the physician's functions as attractive or of a higher order. They are striving energetically to define the special functions of nursing—which are, indeed, not synonymous with being either the physician's handmaiden or his lesser technical aide.

The physician, in any new arrangement, will carry a heavier load of responsibility than other health professionals. His legal accountability will, likewise,
be disproportionate. These are essential consequences of the greater depth of his knowledge and skills in certain of the more severe acute and chronic illnesses.

The physician will be able to share these duties to a significant extent if he is willing to give his benediction to the functions and tasks carried out under his supervision by his assistants. The patient's acceptance and satisfaction will depend upon the degree to which the physician explains the role of the assistant and supports that role as an essential ingredient in modern day health care.

SUMMARY

Satisfaction of the major needs of the public for acute and chronic medical care is dependent upon the redeployment of the functions of the members of the health care team. In the foreseeable future, there will not be sufficient physicians specifically trained to provide primary and chronic care to all the people in America. Extending the role of existing health professionals and training a new category of physician's assistant are feasible and necessary measures, which must be instituted now.

The redeployment of personnel and functions demands a cooperative effort among all the health professions, with a special responsibility for leadership devolving upon the physician. An effective, cooperative effort cannot help but eventuate in a Greater Health Profession, painful as the yielding of prerogatives will be. The alternative is to run the risk of creating
a Lesser Medical Profession out of public desperation—one constituted of irregular practitioners created to satisfy overwhelming needs not energetically enough addressed by all of us. I hope that our corporate sense of moral responsibility for the health of all our people will prevent any alternative except that of a Greater Health Profession, singlemindedly devoted to the best health care our society can provide for its citizens.
REFERENCES


3 National Commission on Community Health Services: Health is a Community Affair, Bethesda, Maryland, 1966.


