Finally, the developers of the standards coined the acronym AGPALL—because they couldn’t think of another word for the phenomenon of “a governmental presence at the local level.” The premise is that the standards represent what the citizen has the right to expect from his/her community. It then makes the role of local government—the local health department in many cases—not a series of explicit activities, categories or programs, but rather that of an overseer, assuring that the community has either the needed service level in all areas or a rigorous strategy to achieve at least minimum necessary services. The exact contribution which the four walls of a public health department might make to any of these objectives would then vary according to community need, alternative delivery approaches, and the negotiated reasonable expectation up to or exceeding the minimum.

Equally as important as this new conceptualization of what is meant by “standard” is the establishment and testing of a process which translates these standards into a reality for local community health programs. The California experience carves out the ground rules for the decade of revenue sharing (block grants) in which federal categories (the old method of “protecting” selected health agendas) give way to agreed upon inventories of necessary community health services. The process by which each community sets its priorities is based upon negotiation rather than some sort of lockstep federal reporting of activity and compliance. The California experience suggests that negotiation provides a process which is satisfactory to local and state authorities—each with its own commitment to achieving better health for the public—and at the same time furnishes a forum in which unmet needs and incompletely pursued obligations can be responsibly arrayed and addressed.

Dr. Weiler’s report indicates that standards can be agreed upon and that a process works by which communities may hold themselves accountable and reach satisfactory accommodation with one responsible state health agency (which receives block grant funding from federal government). Several challenges and opportunities seem unavoidable if and when this process moves forward:

- Community health advocates, concerned that one interest will be compromised in the name of expediency, will have a frame of reference to argue for their cause against clearly defined competing priorities. As cut-backs come, we will want to permit and encourage such rationality.
- Responsible public officials, concerned that in the blush of enthusiasm over “no strings” granting funds will simply “disappear” at the local level, now have a framework for documenting responsible management and cost-effective achievements.
- A responsible Congress and Administration, wishing to cut unnecessary federal bureaucracy and reduce burdensome reporting requirements on the other hand without losing touch with necessary health priorities and vital federal roles on the other, can understand what the resources are doing without mandating an inappropriate homogeneity and a burdensome plethora of reporting systems.

It is paradoxical that such a process is reaching fruition at this time in the evolution of our nation’s public health policy. The model standards were developed with the notion that they would be used as a tool for the allocation of new resources against competing priorities, as Dr. Weiler suggests; they may be equally useful when the question of reductions in the face of crying needs on many fronts must be addressed, but with a different approach. It is also paradoxical that a mechanism to establish relative uniformity across the nation (in the light of the wonderful uniqueness of each local public health endeavor) should emerge at a time when the federal mentality seeks to dismantle critical national roles in the name of “new federalism.” The role of national uniform data bases, derived from important public health outputs and the processes which go into achieving them, is well known to every public health professional who has ever called the Centers for Disease Control or used the National Public Health Program Reporting System; yet critical epidemiologic intelligence and other essential data bases may be allowed to wither away. The role of the federal government in providing leadership, guidance, and catalysis is of crucial importance, yet such a role seems passé. The rhetoric of “cutting administrative overhead” (however small in relation to other federal outlays) is invoked as an excuse for cutting our very lifeline.

Let us be sure, then, that the work which has gone into the development and testing of model standards for community preventive health services is harnessed to the goal of health advocates nationwide: first, to establish local priorities so that the most important programs can be salvaged under current fiscal realities; and then to build from there to the level of service every community has the right to expect.

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REFERENCE

Medical Care in China: Equity vs Modernization

The article by Gail Henderson and Myron Cohen in this issue of the Journal is an important contribution to two different but closely-related literatures. The first is the extraordinary output over the past decade—not only in China and the United States but in many other countries as well—on medical and health care in the People’s Republic of
China. Parts of this literature are "macroscopic" attempts to take a broad, analytic, often normatively and comparatively evaluative view of the entire system or of its major components. Such analyses have the considerable advantage of an overall view of the system but suffer from inability to look closely and critically at its specific application in a particular area—a serious flaw in discussing a system that serves one-fifth of the world's people living under a diverse variety of ecologic, economic, social, and cultural circumstances.

Other parts of the China health literature are "microscopic" observations and analyses of the operations of a specific aspect of the system in a specific area. While much of this literature is published by Chinese investigators in the Chinese language and is therefore inaccessible to most US readers, some is becoming available through the English-language edition of the Chinese Medical Journal and through the path-breaking series of articles on public health care in Shanghai County recently published in a supplement to this Journal.

Henderson and Cohen report on an example of specialized urban medical care in China. Their description and analysis of the referral patterns and cost of care for patients in an infectious disease unit in a large, urban teaching hospital is one of the first in-depth studies by Americans on any aspect of China's medical care. Enormous difficulties of access, language, and culture had to be overcome to obtain the data—and the authors are to be commended on the data collection, the cogency of their analysis, and the clarity of their presentation.

There remain, nonetheless, a series of problems with "microscopic" studies in China, some of which were reviewed in the editorial by Myron Wegman that accompanied the publication of the Shanghai County supplement in this Journal. In a country in which services are characterized by decentralization and local autonomy, care must be taken not to generalize from observations severely limited in space and time to the current status of the entire system. Compounding the problem in this case is the fact that the institutions in China in which foreign medical experts are likely to work for any extended time are almost always urban-based and are usually among the most technologically-advanced, though far less so than comparable institutions in a developed country. Data collected by visiting scientists are limited to those available in the particular area or institution and the problem studied must be necessity be opportunistically chosen. This may be particularly troubling if the problems chosen for study (such as referral to a tertiary care facility, in this case) or the area studied (such as a relatively well-off county abutting a major city, as in the Shanghai County study) are a small part of the overall medical care system or are atypical.

The other literature to which the Henderson and Cohen article makes an important contribution is that of equity of access by patients to tertiary care—whether in developing or developed countries. This body of literature is even more methodologically mine-laden than the China health literature. In order to critically examine the access question, an investigator would have to study appropriately-selected sample populations from a variety of geographic, socio-economic, and cultural circumstances to determine if patients with equivalent needs for medical care have been offered equivalent medical care without differential financial, travel, institutional, or other barriers. Note that the verb is "offered" rather than "received." Equity does not demand that the patient or family accept the care offered. In the United States, for example, one would demand on the basis of equity that a patient be offered access to blood transfusion or other necessary medical procedure, and that all reasonable efforts be made to explain its importance, notwithstanding the fact that the patient may refuse the service because of religious persuasion. In China, with its enormous cultural differences between urban and rural areas, and from region to region, such distinctions are particularly important.

If the sample, as in the Henderson/Cohen study, is not community-based but based on a particular tertiary care unit, a number of other methodologic issues arise. For example, are patients from a distant area referred to the unit in fewer numbers or at a more advanced state of the illness than are patients from closer areas because there are adequate secondarv care institutions much closer to them? If so, transfer to the tertiary care facility in smaller numbers or at a later point in the illness may represent better, rather than poorer, access to medical care. This is not to suggest that the technological level of medical care in China's rural areas is adequate by the standards of industrialized countries or that the referral pattern Henderson and Cohen document is not based, at least in part, on less equitable access to tertiary care for China's rural people than for its urban population. Rather it is to suggest that a sample of patients in a tertiary care unit is a methodologically-dangerous starting point for a study on equity of access to appropriate medical care.

This methodologic problem can be overcome somewhat, under special limited conditions, by studying all the institutions in a broad catchment area that offer a particular service so as to account for all patients in the area receiving the service. A recent example of such a study involved the 539 patients in Erie County, New York on whom coronary artery bypass surgery was performed during a 12-month period. Patients residing in the city of Buffalo and those from census tracts in the lower quartile of median family income had "dramatically lower rates than did others in the county." Although the service offered is still controversial, the study offers additional evidence that technological advances in the United States may increase rather than decrease the inequities between poor and rich and between racial minorities and Whites. Can research and development on such technology at public expense—and its performance in institutions publicly subsidized—be justified in a society that allocates the technology inequitably?

In China, as Henderson and Cohen note, there is evidence that specialized medical care is distributed more equitably than in other developing countries. Perhaps of even greater importance, the fundamental priority for resource allocation by the Ministry of Health (which through the local Bureaus of Public Health controls essentially all preventive and therapeutic services and professional education in China) still seems to be prevention. According to the World Bank and other international agencies, China now has
the highest life expectancy at birth of any country at its level of gross national product per capita with the exception of Sri Lanka.7 The preventive services that made this possible—such as provision of safe water supplies and, even more important, efforts to ensure adequate food, housing, clothing, and basic literacy for all of China’s people—still appear to be highly ranked national priorities. The widely-emulated barefoot doctor and the cooperative medical care services in the rural countryside not only still exist but are being strengthened in a number of ways. The overall number of barefoot doctors has decreased from 1.8 million in 1976 to 1.4 million at present, largely because of the introduction of examination and certification procedures. Nevertheless they remain a bulwark of rural primary care and their technical quality is clearly improving.

Recent developments, however, may pose some threat to what has been accomplished. For example, hundreds of Chinese physicians now studying high technology therapeutic medicine in the United States will return to China and are likely to contribute to a shift in the balance of resources, between prevention and treatment, between city and countryside, between professionalized, centralized, specialized services and decentralized primary care services provided by locally-trained personnel. Hopes for continued progress and increasing equity are still high, but dangers to continuation of the unprecedented progress China has made are clearly present.8

Henderson and Cohen have delineated not only some of the dangers to equitable resource allocation that the introduction of highly specialized medical care services brings but also some of the ways to combat them: avoidance of unnecessary hospitalization, avoidance of use of expensive medications (and I would add laboratory and surgical procedures) without documented benefit, and greater transfer of technologic resources to rural institutions. Whether China’s leaders can move in this direction in medical care and maintain their commitment to prevention, at a time when they are looking to the United States for many of their models and seem to view rapid “modernization” as the central solution to China’s problems, is a critical question, important not only to the people of China but to people everywhere.

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REFERENCES

Health Services for Mentally Retarded People in Community Residences:
Problems and Questions

Under the influence of the concept of normalization,1 changing social policies, favorable legislation for disabled people, class action suits which delineated the rights of mentally retarded people,2 and intensified processes of deinstitutionalization, the mentally retarded population in traditional public residential facilities (PRFs) was reduced by approximately 30 per cent during the decade of the 1970s.3 Simultaneously, new community-oriented residential facilities (CRFs) were developed which, by 1977, housed more than 60,000 mentally retarded people.4 In effect, a new community residential system was created for a portion of the mentally retarded population.

The lack of standards for CRFs in terms of size, staffing patterns, and terminology has partially frustrated efforts to obtain accurate data concerning national trends in the community residential system.4 Many of the CRFs were small; in 1977, for example, 73 per cent of the CRFs in a nationwide survey had one to 10 occupants and another 15 per cent had 11–20 occupants.4 By comparison with traditional PRFs, these facilities were too small to provide intramural services. Instead, it was anticipated that the occupants would utilize extramural, “generic” services in the community in keeping with the principle of normalization.1,5 In effect, the new community residential system shifted the dependence of mentally retarded people from the segregated health services of institutions to the existing health services of communities. There was no a priori evidence, however, that access to the community health system could be readily achieved by this group, that professionals would be prepared to respond appropriately, or that the services delivered would meet the requirements of the population. To date, the problems associated with the delivery of health services to this population have not been sufficiently explored.

In this issue of the Journal, Gotowka and Johnson6