Community Based Nursing Service As An Alternative-
Background Forces and Current Practice.

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1. Introduction:

Health care as an ever unsatiable need has been a major concern for every nation in this scientific era of human history. The health care problems stem directly from the gap between knowledge and medical technology available today and the delivery of the fruits of medical progress to the millions of people who have need of them. This point has been emphatically made by Rogers when he said that "despite having built the most impressive biomedical science technology programs to be found anywhere in the world and the training of a superb group of young men and women as physicians and nurses, we are confronted with a wholly inadequate fit between our fine medical technology and the health requirements of many of our citizens."[1]

High cost, persistent health problems, inaccessibility of health care services and inequities in health levels and health care among different groups of population are the features of health

1) D.E. Rogers, The American Health Care Scene. Views from a foundation perspective. New England Journal of Medicine, 288 : 1379 (June) 1973.

care problems to be heard almost any part of the world.

Korea is no exception in its concern about the health care of its population.

II. Background for the Community-Based Nursing Movement in the U.S.

The major shift of emphasis away from hospital toward community nursing has occured in response to the changes in the society of its need for health care which, because of many inadequacies, has reached a state of crisis.

The health care scene in the U.S. around the middle of 1960's has been characterized as sky-rocketing health care cost, inaccessibility of medical care and persisting health problems. Many changes have been proposed and multiple innovations have been introduced including more active role of nursing in expanded responsibilities.

A. Health care Scene in the U.S.

The health care crisis of America in the late 1960's can best be summarized by quoting French and Egeberg's presentation to the president of their assessment of the health care crisis; "This nation is faced with a breakdown in the delivery of health care unless immediate and concerted action is taken by government and private sectors. "Expansion of public and private financing for health services created demand for health services far in excess of the capacity of our health system to respond. The result is crippling inflation in medical costs causing vast increase in government health expenditures with little return, raising private health insurance and reducing the purchasing power of the health dollar of our citizens."[2]

The subcommittee on Executive Reorganization and government Research in its 1968 hearings on health care in America found that a large number of the poor received improper care or no care at all, and the middle class felt the financial pressure of the high cost of care and lived in fear of a prolonged and expensive catastrophic illness. The care both received often was fragment and impersonal, and accidental factors such as where a man lived or worked often determined the quality of his health care and health insurance. Health insurance plans, by generally covering only care administered in hospitals, encouraged the most expensive care possible. In addition, by covering treatment instead of prevention, the plans were paying for sickness more than health. As for the health services and professions, they had failed to keep pace with advances in medical science and changes in society. Specialization had reduced the number of physicians serving the basic health needs of population, and many truned to hospital emergency rooms as their family doctor, placing heavy and unexpected demands upon their facilities. They appeared to be organized more for the convenience and concerns of their practitioners and institutions than for the health needs and financial security of the patient.[3]

Speaking to the inequities of health care, Senator Edward M. Kennedy says in his address to the conference on Medicine in the Ghetto, that "In the Ghettos of our cities, medical care is available but only if one travels far enough, waits long enough, and endures the crowds, the inconvenient hours, the understaffed facilities." Referring to the crisis nature of health problems of the poor, he continues to say that the poor have traditionally neglected their medical needs. The neglect is there, but it is caused in large part by the simple belief of the

2) Joseph T. English., The changing Scence II, JOME 45 p. 68, Dec. 1968.

3) excerpt from Report No. 91—809, U.S. Government printing office, 1970, p. 28—32.

poor that the vaunted institutions of American medicine were never intended to serve them.[4]

Indicators of the health crisis often cited include high maternal and infant mortality rates, the death of prenatal care, poor and inadequate care for children and a high incidence of untreated handicapping conditions for both young and old.

Lerner says that "perhaps, the most sensitive index of health conditions within a community is the infant mortality rate."[5] Lewis uses this index to point out that in 1969 there were twenty-two countries with lower mortality rates than the United States.[6] Hellman also shows that the United States had a higher neonatal mortality rate than sixteen other countries, and a higher maternal mortality rate than ten of the reporting countries[7]

A clear inverse relationship between family income and infant mortality was pointed out by Greenberg with the fact that infant mortality rates were forty percent above the national average in the seventeen states with the lowest per capita income. In other words, "an infant born of poor parents in this country has twice as much risk of dying before reaching his first birthday as does the non disadvantaged."[8]

He goes on to emphasize that the cycle of deprivation starts off with the lack of proper health care during pregnancy. Out of some 3.5 million birth occuring annually in the United States, at least 500,000 are by women who have received inadequate prenatal care or none at all. About half of the expectant mothers in poor families go through pregnancy without the required medical attention. The lack of such care and poor nutrition lead to a high rate of stillbirths and premature births. They also result in complications of pregnancy and child-birth that can inflict irreversible damage on the offspring and sometimes kill the mothers.[9]

Senator Kennedy also cites statistics that show a profound disparity of rate of sickness among poor: Death comes earlier to the poor. A child born to poor parents has twice the risk of dying before reaching his first birth day and his chance of dying before age 35 is four times greater. Illness is twice as frequent among families with annual incomes below the poverty line and chronic illness is four times as great; The poor suffer three times as much from heart disease, seven times as much from eye defects, and five times as much from mental retardation and nervous disorders; Forty five percent of mothers delivering babies in public hospitals have had no prenatal care; Fifty percent of job corps trainees have never seen a doctor, Ninety percent have never seen a dentist. Three-quarters of the eigthteen-year olds rejected by the Selective Service system for health reasons need immediate medical attention; and concludes that by almost any standard, visits to doctors or preventive services, or incidence of disease, the data show a clear progression in which the poor have a higher incidence of disease and lower access to medical facilities than other social groups.[10]

4) I Edward M. Kennedy, "The responsibility of Government for Leadership in Health Care," Medicine in the Ghetto, Meredith Co. 1969, pp. 269—280.

5) 2 Monroe Lerner, Social Differences in physical health, Poverty and Health: A sociological analysis, a commonwealth Fund book, Harvard University press.

6) Anthony Lewis Physician heal thyself: I The New York Times, Oct. 2, 1971, p. 31.

7) 4 Louis M. Hellman, Nurse midwifery, annals of New York Academy of Sciences Education in Health Related Professions ed. Benton and Gubner CLXVL. New York: Academy of Socience, Dec. 1969, p. 897.

8) Selig Greenberg, The Quality of Mercy: A Report on the Criticalc Condition of Hospiatl and Medical Care in America, New York: Antheneum, 1971, pp. 107—8.

9) Greenberg, Quality of Mercy pp. 106.

10) Kennedy, Responsility of Government for Leadership in Health Care, pp. 270.

B. Causes of Crisis and Changes Proposed.

According to Ramey, the problems contributing to the health care crisis may be subsumed under three main headings: 1. the increasing incidence of certain disease conditions; 2. greater demands by the public; and 3. inadequacies in the delivery of health care. Incidence of prematurity, VD, heart disease, cancer, stroke, emphysema, child abuse, drug addiction, mental illness, a high infant mortality rate, tuberculosis, epidemics of preventable communicable diseases and self-induced health problems such as smoking, sexual promiscuity or improper hygiene or nutrition were increasing.

The rising demands of the public attributed to the more positive new definition of health as a birth-right geared with increased purchase power of the public made possible through the creation of Medicare, and Medicaid, and to the federally sponsored programs such as OEO and Model cities which have created mechanisms of community participation in planning and execution of health care to the community.

Maldistribution of health manpower in geographic regions and specialty areas, unwillingness of many health care professionals to update their knowledge and skills and to comply with community demand, and the lack of one overall system for the provision of health care were identified as the causes of failure in the delivery of health care.[11]

Fuchs denotes that the health care crisis is not basically a medical problem, but rather an economic one, a matter of choices among competing needs, and concludes that "the differences in health levels today between the United States and other developed countries or among populations in the United States are not primarily related to differences in the quantity or quality of medical care. Rather they are attributable to genetic and environmental factors and to personal behaviors manifestations of life style."[12] As contrasted to relative unimportance of physician to pt's health status, Fuchs believes that the physician's influence on medical cost as a principal decision maker is overwhelming and thus, suggest that a concern with cost requires concentrating on physician, his training and his incentives and constraints in his practice, together with moderating the utilization of hospitals.[13]

The problem of access to health care fall into two main categories, "special" and "general" According to Fuchs, the special problems of access are those faced by particular groups in society-the poor, the Ghetto dwellers, and the rural population, and are similar to those they face in obtaining other goods and services.

The general problem of access that is felt even by individuals and families who have enough income or insurance to pay for care and are not disadvantaged by reason of location or race, exists mainly with respect to primary care, emergency care, home care, and care outside customary working hours. The problem arises principally from the growth of specialty and subspecialty medicine, so he concludes that the solution does not lie in simply increasing the number of physicians.[14]

A commitment to provide a minimal standard of health care to all Americans who require

11) Irene G. Ramey, "The Crisis in Health Care: Fact or Fiction? Health Care Issues, ed. Madeleine Leininger Philadelphia: Davis Comp. 1974, p. 17–26.

12) Victor R. Fuchs, WHO Shall Live?: Health Economics and Social Choice. New York; Basic Books Inc. 1974, p. 6.

13) Fuchs, WHO shall live, p. 145.

14) Ibid, p. 15.

such care regardless of their ability to pay or their geographic location is Mechanic's highest priority for the national goals in delivering health care service. Implicit in implementing this priority is a program to distribute manpower and facilities so as to insure that those in need have accessible services.[15]

Gorman declares that there are three most malignant and devastating social constraints to health care delivery system in the United States namely; medial imperialism, racism and poverty. Quoting Friedman's observation that the physician has authority to direct and evaluate the work of others without in turn being subject to direction and evaluation by other health workers, Gorman says that medical dominence over all health related activities in the hospital setting is perpetuated by medicine's private practice model, and as long as health services are given in the hospital, the physician will ramain dominant.[16]

A similar view has been expressed by Norris when she attributed health care crisis to the system that makes everyone, patients and professionals alike, wait until the physician has seen the patient, suggesting a new system which allow direct access to clients with diverse health care needs by health personnel with diverse skills as a solution to the problem.[17]

Leininger also speaks of uniprofessional dominance by medicine which hinders the optimal utilization of the health personnel already available. Infering general systems theory Leininger attributes the crisis to present health care system, a closed system, which permits only limited interchange between health manpower resources and energy with the environmental needs, and this closed system is perpetuated because it is predominently controlled economically, politically and professionally by the medical profession. Leininger proposes an open health care system which is flexible, diverse, and oriented to the client and community and which will acknowledge, utilize, and distribute to best advantage the skills and services of all health professionals concerned with patient care.[18]

As to the racism in health care in the U.S. Hare, in speaking of medicine in Ghetto says in the most provocative terms that "with medicine we come to one of the most tragic features of the system of racial oppression it operates overall as a mechanism, so to speak, for a type of genocide."[19] And needless to say that the evidences of disparity can be readily found in any health-related documents.

Weckworth saw that the major difficulty in the solution to the problem lies in the legal restrictions prohibiting substitutions or interchange of skills, and the vested interests of professional and skill groups to prophibit others from using the skill they have, and stresses that "the time is ripe to redo whatever legal, customary or vested disciplinary constraints still inhibit the interchange and substitution of skills. New skills and new groupings of such skills are basic to the solutions of problem."[20]

Moxley urges that the gray zone between the function of the doctor and the nurse should be better defined, and if this area needs special attention, then the more ordered efforts be

15) David Mechanic, Public Expectations and Health Care, John Wiley & Sons Inc. 1972, p. 18.
16) Leah M. Gorman, Societal Constraints to Comprehensive Health Care. Nursing Forum 12 : 175 (No.2) 1973.
17) Catherine M. Norris, Direct Access to the Patient, American Journal of Nursing 70 : 1006, May. 1970.
18) Madelaine Leininger, An Open Health Care System Model Nursing Outlook 21 : 171—2 March 1973.
19) Nathan Hare, Does Separatism in Medical Care Offer Advantages for the Ghetto? Medicine in the Ghetto ed. Norman, N.Y.: Appleton-Century-Crofts. 1969, p. 43.
20) Vernon E. Weckwerth, The Interchangeability of Skills, School of Public Health University of Minnesota, 1967.

focused on the development of a physicians assistants, and in such an eventuality, nursing has to decide whether to expand to encompass this new role or whether to allow it to be filled by others[21]

Changes proposed center around the creation of an effective health care delivery system which provide a wider access for all Americans to quality care all along the health-illness continuum, from preventive and health maintenance care to curative and restorative care. Proposals include: a comprehensive financing mechanism for all health care in the form of a national health insurance; training of more physicians with special emphasis on minority groups through the expansion of medical schools; better utilization of avaliable health manpower with emphasis especially on the role of nurses in expanded responsibilities; and the shift of focus from hospital-sick care to community-based preventive and comprehensive care through the creation of Health Maintenance Organizations and neighborhood health centers and/or through expansion of community hospital ambulatory health services.

As to the alternative patterns for financing the care, Fein maintains that reliance on charity of medical personnel or federal government funded neighborhood health centers or existing medicaid program would not be a solution; the services available to all of the Ghetto population is not likely to be enacted, and cutbacks in times of tight budgets and cost escalation in health services for the poor is not likely to be readily accepted. Medicaid programs, besides its effect of crippling welfare system, is likely to be underfunded and is subjected to the charges of abuse by the recipient and provider. Fein suggests that the separation of service from present mechanism of financing is necessary, and opts for national health insurance or universal health insurance plans which would permit the development of model systems of delivery that would treat all individuals on the same basis and their operations financed out of central funds provided for through the general revenue derived from a progressive tax system or a mechanism of tax credits or out of a Social Security Trust Fund operations. He argues that in the absence of programs to increase the total supply of services available and to alter the characteristics of the medical market place, the mere solution to the financing problem would not guarantee better health care for the poor and says that "it is essential that a better financing mechanism be coupled with an improved distribution system and with the development of better organizational pattern."[22]

Brindle and Pollack join with Fein in the goal to achieve a situation where the amount and quality of medical care that an individual receives is not a function of his income. Illustrating their success with Helath Insurance Program of Greater New York, Brindle expresses his belief that "One door-one class" care can be achieved through development of a prepaid caseload for new community health centers so that the centers serve a cross-section of the wohle population in the community and not just the poor, proclaiming that "What is needed is full entitlement, a full membership ticket into the mainstream of medicine."[23]

Pollack maintains that the cruicial decision to be made is that whether we wish to continue to have two separate systems of financing-one for the population at large and another for the

21) John H. Moxley, The Predicament in Health Manpower, A.J.N., 68 : 1007 July 1968

22) Rashi Fein, How can Medical Care in the Ghetto be Financed? Medicine in the Ghetto. ed. Norman. p. 223—229

23) James Brindle, What is the Impact of H.I.P.? Medicine in the Ghetto. p. 231—234.

poor-or whether we wish to provide at least for basic financing under a single scheme. "Two systems of financing will continue to produce two levels of care. In a single system, support for the poor would remain inviolate, the whole program would be less vulnerable to cutbacks."[24]

From the standpoint of limited resources Fuchs and James note that we can not have all the health care we want, and suggest that we as individuals and as a society make decisions about health care priorities. James cautions the general trends for the emphasis on quantity from more of economic perspective rather than the quality of health care from expanded knowledge base; further quality reduction may result through the capitation-reimbursement plans. He also warns that the effect of the rising expertise of biomedical engineering the cost of which would be tremendous, and suggests that teaching hospitals with strong departments of community medicine with focus on prevention and family medicine would make an unique contribution.[25]

Contrary to James' concern on quality of care, Fuchs maintains that there are ranges of choices to be made among competing wants on many levels and also within the health field, and that health plans from economic perspective would not necessarily reduce quality, suggesting that the decisions about expanding or contracting particular programs should be based on their respective marginal benefits,* so that each incremental yield of any program to be equal to the incremental cost of the program.[26]

In regard to health manpower, generally two opposing views are identifyable. Proponents for the training of more physicians, seems to work with underlying assumptions such as 1. General marketing strategy will be equally applicable to health manpower problem, thus, increasing supply of physicians would force significant reduction in the competition of health market, ultimately driving down prices and costs and resolving the access problem 2. Importation of foreign trained nurses and physicians at current ratio has self-limiting factors and eventually would have a detrimental effect on health planning for the nation; and 3. Different cultural and social groups have different needs and require special considerations of cultural variables, thus, more or less, proportionate representaton by different cultural and racial groups in health personnel will be ideal.

Hare, in speaking for the advantages of separatism in medical care for the Ghetto gives his rationale for affirmative answer to the separatism as "the medical needs of the black community currently differ not only in quantity but in nature from those of white community..." He claims that the needs can not be met by white physicians or "whitened" black physicians without understanding of the black culture, thus "a system of black medical self-determination is necessary to effect unlimited improvements even within the confines of existing laws."[27]

According to Hatcher, shortage of black physicians is critical today. There are only about twenty black physicians to each 100,000 black citizens, and the proportion of black physicians to all American physicians is only 2.2% while more than 10% of the nation's citizens are black-

24) Jerome Pollack, What is the Role of Prepayment and Health Insurance for the indigent of the Ghetto? Medicine in the Ghetto. 215—221.

25) George James, Do Hospital-based Services and Private Enterprise Offer the Best Hope for Improved Health in the Ghetto? Medicine in the Ghetto. p. 239—249.

26) Fuch, Who shall live? p. 20.

* Marginal benefits and costs are those resulting from small changes in inputs. Fuchs, p. 19.

27) Nathan Hare, Medicine in the Ghetto, p. 47.

discrepancy attributable to the traditional discrimination in medicine.[28] Hatcher maintains that something more than equal treatment for black students will be required in order to help recruit talented young blacks for medical careers to fill the openings medical schools begin to create for them;

A better premedical counseling, development of a larger resources of prospective students, and flexible admission criteria and supplementary corrective measures for deficiencies are essential to achieve the goal.[29] Except for these minority groups however, there seems to be a general censensus that mere increase in the number of physicians would not solve the problem. Problem is rather in the distribution of manpower in geographical and specialty areas and with access to primary care where and when they are needed. Suggested remedies seem to focus more on strategies for a more effective utilization of whole range of available manpower with the development of a better distributing system of health care.

Aside from multiple supportive service health workers being brought into the health scene, special focus has been placed on bridging the gap in the gray zone between the functions of medicine and nursing. The concepts of physicians' assistant and expanded of nursing role has been wide spread with various experimental programs began to mushroom with the Pediatric Nurse Practitioner Program at the University of Colorado and the Medex program at Duke University as a starting point.[30]

C. Recent Major Innovations in Health Care Through Public Machinery.

Major thrusts in the changes of health care can be said to have emerged from direct intervention of the Federal government. Government's concern over health care of population has been expressed through the series of legislative acts and their resultant implementations. Among those, recent major legislative acts which has had greatest impact on health care delivery include: the 1965 Amendment of Social Security Act creating Medicare and Medicaid; the authorization of O.E.O. for the establishment of comphrehensive neighborhood Health Center in the 1966 Amendment of Economic Opportunity Act; 1972 Amendment of Social Security Act mandating the establishment of Professional Standard Review Organization; Health Maintenance Organization Act of 1973; and now pending National Health Insurance Policy.[31)-32)]

The initial effort of federal government to overcome financial barriers to health care among indigent population with declaration of health care as birth-right has been met with the crisis resulting from the inability of health care systems to respond to the increased demand. Skyrocketing health cost culminating health expenditure to eight percent of total Gross National Product by 1973,[33] and problem of access with hightened expectations of the genral public were the consequences, finally, leading to the 1972 Amendment of Social Security Act to

28) Richard Gordon Hatcher, Does Gary, Indiana, Reflect the National Problem of Medicine in the Ghetto? Medicine in the Ghetto, p. 21—23.

29) Hatcher, Medicine in the Ghetto, p. 28—29.

30) Katherine B. Nuckolls, Who Decides What the Nurse Can Do? Nursing Outlook 22 : 626, Oct. 1974.

31) Ernest W. Saward and Merywyn R. Greenlick, Health Policy and the H.M.O, Health care dimensions: Barriers and Facilitators to Quality Health Care ed. Madeleine Leininger, Philadelphia; F.A. Davis Co. Spring 1975, p. 61—78.

32) Jame J. McCormack, Current Public Policy and Medical Care Evaluation, Health Care Dimensions: Barriers and Facilitators to Quality Health Care, p. 47—57.

33) Fuchs p. 10.

monitor the quality and cost of health care services financed by three public programs: Medicare, Medicaid, and Maternal and Child Health Services.[34]

The O.E.O. and HMO concepts as comprehensive health care plan seem to have a wide-spreading acceptance as viable innovations to the health care problem. According to English, O.E.O. Neighborhood Health Center is not the answer; however, it does represent a major step by the Federal government to assure comprehensive health care for the poor on a large scale. "A program derived from the needs of the people to be served: This is the essence of the O.E.O. concept of comprehensive health services."[35] is the interpretation he has given for the model of comprehensive service the legislature indicated. The fact that O.E.O. framework addresses itself to the needs of the indigent community as they themselves perceive it, with built-in mechanism for community participation in planning, executing and total operation of the center seems to be the key factor for its wide acceptance. Health centers have various programs to fit the needs of particular community including various educational programs for job training as well as health-related activities and provide job opportunities for the community people where they see fit.[36]

Greenlick and Saward in their writing on Health Policy and the H.M.O., say that "The nation is at the beginning of a major new thrust in health policy-the era of the Health Maintenance Organization. It has been widely heralded for the past two years."[37] Health Maintenance Organization has been operationally defined to mean "a network of services under a central direction that is available to a defined population and financed with prepaid per capita payments."[38] It was further defined as an organization of comprehensive medical services with the understanding of a guaranteed access to these services in relation to medical need for a voluntarily enrolled population. H.M.O. is intended to provide the inherent motivation for any prevention and any cost-effective disease detection that exists, and by providing a strong financial incentive for better preventive care and for greater efficiency, H.M.O. can increase the value of the services a consumer receives for each dollar.[39] There are some 150 H.M.O.s in varying stages of development and it is further predicted that H.M.O. concept will further spread as the National Health Insurance Plan builds firmer ground.[40]

As has been stated before, Anderson says that "one of the current and key pieces of pending legislation is National Health Insurance and there is little doubt that a compromise will soon be reached to the various bills under consideration. Points of difference regarding the extent of coverage, the role of the federal government and private insurance agencies and the cost are yet to be resolved."[41]

Some proposals only deal with coverage of catastrophic illness (major-risk insurance) while others deal with general comprehensive care. Martin Feldstein, as a leading proponent for

34) McCormack Ibid, p. 48.
35) Joseph T. English, Is the O.E.O. Concept-The Neighborhood Health Center-TheAnswer? Medicine in the Ghetto, p. 261.
36) Gerald Sparer and Anne Alderman, Data Needs for Planning Neighborhood Health Centers AJPH 61 : 796—, 806 April 1971.
37) Ernest W. Saward and Merywyn R. Greenlick Health Policy and the H.M.O. p. 62.
38) James J. McCormack Current Public Policy and Medical Care Evalustion. p. 49.
39) Saward Merywyn, p. 63.
40) Edith H. Anderson, The Political Context and Process of Health Legislation Health Dimensions: Health Care Issues. p. 113.
41) Edith H. Anderson, Political Context and Process of Health Legislation, p. 112.

major-risk insurance argues that the more comprehensive the coverage, the greater the "welfare loss" entailed in society, collectively over consuming medical care at the expense of other goods and services.[42] But many others are concerned more with comprehensive"first dollar coverage." According to Fuchs' analysis, by major-risk insurance approach, there would be less incentive for persons to seek early care or preventive treatment; a large administrative burden on both patients and government; there can be no assurance that utilization will be detered once the deductible had been satisfied since it is the marginal expenditure over which the patient frequently has the most discretion; and finally, major-risk approach concentrate exclusively on the patient and does nothing about organization of care, problem of access, or efficiency of delivery systems.[43]

Perceiving the impact of the eventual national health insurance plan on nursing as a mjaor determinant of utilization, education, and compensation for nursing, A.N.A. and N.L.N. have made statements on what they consider necessary components of any from of national health insurance. These components include a guarantee of comprehensive health services for all people, meaning the total range of health care services: preventive, health maintenance, diagnostic and treatment services, protective services, emergency services, primary care and community health services, high level utilization of nurses and other health personnel, provisions for quality or peer review, and joint participation of consumers and providers.[44][45]

In line with increased public funding of health services, quality control of health care has emerged as an important issue in discussion regarding reorganization and restructuring the health care system. McCormac knotes that "with the rapid growth of the health industry and increased public payments, the subjective assessments made by individual practitioners no longer constitute a viable response to quality control requirement. Persons are now cared for by multiple types of health care practitioners, each of whom must have some role in quality and cost control."[46] Speaking of cost and quality control of health care, Fuchs warns that "unless the financing system is used to modify the behavior of physicians and hospitals, a national health insurance plan might do more harm than good."[47] McCormack presents two recent legislations as the major effort of government addressing to the regulation of the quality of health care with the purpose of defining and creating systematic national programs for quality and cost controls: The 1972 Amendments to the social security act require establishment of professional standards review organization to monitor health care services financed by three public programs: Medicare, Medicaid and Maternal and Child Health Services; and the 1973 H.M.O. legislation with its claim of a higher quality of health care at lower costs in comparison with the traditional fee-for-service arrangesments, contains major provisions that bear upon the regulation of health care quality.[48] It can be predicted that with the enactment of natioal health insurance and further development of H.M.O.s, the regulation of costs and quality of health

42) Martin S. Feldstein, The Welfare Loss of Excess Health Insurance, Journal of Political Economy 81, No. 2 Part I (March-April 1973).

43) Fuchs, p. 136.

44) A.N.A.'s Position on National Health Insurance, A.J.N. 74 : 1262—3, July 1974.

45) National League for Nursing, Goals for a Natinal Health Insurance Program New York: The Association, Feburary 1974.

46) McCormack, Public Policy and Medical Care Evaluation, p. 48.

47) Fuchs, p. 141.

48) McCormack, Current Public Policy and Medical Care Evaluation, p. 48.

care by the Federal government will be further systematized, and the cooperation by the health professions will increase through the forms of P.S.R.O. or peer-Review arrangements as the current demand for professional accountability rises.

III. Evolving New Alternatives for Nursing.

From the 60's concern of diminishing social effectiveness and questions of relevancy of nursing practice in the face of changing health care needs of the society to the current concerns of professional accountability for ever expanding roles of nurses, nursing in the United States for last decade has been truly in the turmoil of transition in its effort to supply needed man power for the nation's health care needs and in preparation for the challenges of nursing today and tomorrow as they relate to the society's movement toward planning for a better health care for the population in general.

In May, 1973, three national nursing organization, the N.L.N., A.N.A., and A.A.C.N. have issued a joint statement calling for the more extensive and efficient use of nurses in the country's health care system, stressing that it will not be possible to deliver quality health services to people until the potential for nursing's contribution to the health and wellbeing of people is fully intergrated into the U.S. health care system.[49] With the supports given by the report issued by the Secretary Department of Health, Education and Welfare in 1971, and recommendations by the National Commission for the Study of Nursing and Nursing Education to establish joint practice commissions between medicine and nursing in support of extended functions for nurses,[50][51] Bullough states that there are 30 states which have enacted amendments to their nurse practice acts in the last five years to facilitate nurses taking on diagnostic and treatment functions begining with the Idaho revision in 1971.[52]

Having agreed upon the expanded role for nurses, attention needs to be given to the ways and means of expanding services. The editorial of Nursing Outlook, March 1975 depicts today's "Nurse Practitioner" and poses the troubling question whether it is "the way to go"for nursing amidst opposing opinions on the issue-the opponents perceive that previously medical skills and responsibilities does not expand nursing's role but rather denies it, and the proponents believe that new skills are simply new tools whereby patient's needs are more comprehensively assessed, and provide new opportunity for nursing into primary health care.[53] The cruicial questions Weston raises for nursing "whither the "nurse" in nurse practitioner?" can not be answered in the absence of objective data as to how the nurse practitioner functions and the kind of care she gives. Three questions Weston raises are: 1. Does the nurse practitioner combine her skills as a well prepared nurse with additionally acquired medical skills to provide better care for patients and their families?; 2. Is there an improvement in outcome of patient care when a nurse practitioner provides health and medical care as opposed to "other nonphysicians or in fact, physician?; and 3. Is it not an alternative route for physician's assistant

49) N.L.N. Joins, A.N.A., A.A.C.N. in urging wider role for nurses in primary health care. News, National League for Nursing, 21 : 1, 6, May, 1973.

50) Dept. of Health, Education, and Welfare, Extending the Scope of Nursing Practice: A Report of the Secretary's Committee to Study Extended Roles for Nurses. U.S. Government Printing Office, Washington D.C. Nov. 1971.

51) Jerome Lysaught, An Abstract for Action: A Report of National Commission for the Study of Nursing and Education, McGraw-Hill Book Co. N.Y. 1970.

52) Bonnie Bullough, The Law and the Expanding Nursing Role A.J.P.H. 66 : 249—254, March, 1976.

53) Edith P. Lewis Editorial, Nurse Practioner: The Way to Go? Nursing Outlook 23 : 147, March, 1975.

preparation with primary focus in ambulatory medical care? Does one have to be a nurse to do what the nurse practitioner does?. Weston states that the nursing profession has concentrated on legitimatizing these medical functions as nursing practice instead of asking whether or not it was appropriate for nurses to assume such a role.[54]

In an address given to nurse practitioners, Bates speaks to the same issue but with more assertion: "By expanding into medicine, you can now expand into nursing. By your expanding into medicine, the system can now provide less medicine and together with your nursing, it should be better medicine. By doing physical assessment, you can better get at the psychosocial problems. The value of nursing must not get lost in the dominent medical culture. If they do, you just risk the epithet of junior doctor. Our patients do not junior doctors. They need the knowledge and skills of both medicine and nursing. By combining these, you have to opportunity to practice not only in the highest tradition of medicine, but also in the highest tradition of nursing."[55]

A real concern for the professional identify in the direction of changes in nursing has been expressed by Murphy in her questioning whether this change is in accordance with the assumption that the primary function of the nurse is to give care with the warning that unless attention is directed toward the appropriate methods for supporting this primary function nursing must face the basic challenge of the reason for its being. By delineating conceptual difference between "role extension" and "role expansion" as a unilateral lengthening process vs. spreading or a process of diffusion, Murphy suggests that the diffuse change by means of expansion holds promise with the point of departure for the diffusion as that of care.[56] Driscoll, Rogers, and many other nursing leaders also express their concerns about professional identity. Leininger while opting for an accelerated change also warns against the growing trends toward conceptualizing role uniformity, role conformity and role alikeness in all health disciplines, and emphasizes the importance of the discipline of nursing to place emphasis as its central and dominant role upon direct and on-going health care services to people which stresses support, nurturance, comfort, rehabilitation, health counseling, and education measures recognizing role complementarity rather than role likeness.[57]

While heated debates over professionalism and control of the health profession remain to be settled the general consensus is that nursing should be responsive to the changing needs of the society and its evolving health care system. Like it or not nursing is changing and should be changing in order to remain as a viable profession. It is estimated that there are approximately 2,000 nurses prepared for expanded role functions[58] and many more nurses are accepting increasingly more responsible roles in both acute and primary care settings. There is not yet consensus as to who should be trained and for how long, or who should be responsible for the training, however, there is definite demand and trend in total health care system to view

54) Jerry L. Weston, Whither the Nurse in Nurse Practitioner? Nursing Outlook 23 : 148, March, 1975.

55) Barbara Bates, Twelve Paradoxes: AMessage for Nurse Practi tioners, Nursing Outlook, 22 : 686—6, Nov. 1974.

56) Juanita F. Murphy, Role Expansion or Role Extension: Some Conceptual Difference, Nursing Forum IX : 380—389, (No. 4) 1970.

57) Madeleine Leininger Health Care Delivery system for Tomorrow, Health care Dimensions: Barriers and Facilitators, p. 91—92.

58) Lorreta C. Ford Reflection on the Past Decade in Health Manpower, Health Dimension: Barriers and Facilitators, p. 3.

health care problems in terms of consumer (the community) needs beyond the vested interests of professionals and their power struggles.

Kibrick in her editorial writing "Time for new leadership" says, "The nursing crisis is not the result of a lack of planning on nursing's part: rather, it is the result of failure to put professional planning in the proper perspective. For too long, too much of out planning for nursing education and practice has been from the perspective of what is best for the profession. We have not considered the world around us. We have not listened to the consumers." and she continues to say that consumers today are making two separate sets of demands on the health delivery system: one, the curing of illness-the doctor's role; the other, "total patient care," including preventive care, coping with illness, and the eventual restoration of health-the nurse's: potential role.[59]

Having accepted the changing roles of nursing, it is now necessary to take a closer look at the emerging patterns of health care in terms of their underlying philosophies, nature and scope of nursing practice, administrative structures and their financing mechanisms.

A. Philosophies Unerlying the New Patterns of Health Service

Extending health care service to all Americans as the basic goal of whole new movement in health care, several characteristics became outstanding: 1. Focus on the consumer and health care needs of the community; 2. Interdisciplinary collaboration focusing on extension of primary care; 3. Renewed emphasis on prevention and maintenance; and 4. Focus on cost-effectiveness and general efficiency of health care system.

1. Consumer Focus.

"Of the people, by the people, for the people" is the philosophy of the Neighborhood Health Center as Creditor sees it, and he explains that virtually all of the programs have developed vehicles for community participation in the development of plans, policies and operations.[60] English also speakes of the great variety of health purveyers participating in O.E.O. concept of comprehensive health services and various approaches to community participation. Of the total 104 comprehensive health services grants, 63 percent of the grantees represent community action agencies, and another 15 persent nonprofit groups. He also observed that the success or failure of these projects is dependent not upon how much money, either Federal or private, poured into a project, but upon the level of interest and energy a community is willing to put into the effort. Other interesting features observed were installation of coin-operated laundry machines, sewing machines and a kitchen in neighborhood health stations of Lowndes County, Alabama, and a health center constructed by several hundred men of the community of Alviso outside of San Francisco symbolizing a center of life for all the people of Alviso. From these observations and according to O.E.O. concept, English concludes that it is critical for the consumer to be part of the total comprehensive health care picture-not just because the consumer has a right to be part of it, but because it is impossible to design the new technology and the delivery of health care without community participation.He notes, "We health professionals can not do it without

59) Anne Kibrick editorial, Nursin 1973 : Time for New Leadership, Nursing Outlook, 21, Jan. 1973.

60) Morton C. Creditor, The Neghborhood Health Care Center: Where Does the Hospital Fit? American Journal of Public Health 61 : 806, Apr. 1971.

their sense of responsibility, without their partnership, without their help."[61] Witness to the "Consumer-Controlled Nursing" in Alviso Neighborhood Health Center is also given by Lorig.[62]

Echeveste and Schlacter suggest marketing as a strategic framework for health care as todays marketing means monitoring consumer needs and desires and adjusting production and distribution accordingly. To them this approach has a particular relevancy to health care delivery taking account of the fact providers and consumers subscribe to varying definitions, objectives, perceptions and methods of health care, and as a result of these discrepancies, health care services can be underutilized or malutilized especially when the focus shifts from illnesscurative care to health maintenance-preventive care[63]

The importance of consumer-centered approach stems not only from the requirement of health care but also from cultural differences. Variations in the concept of health and illness and utilization pattern of health care has been well documented in various literatures. Thus, Shlotfeldt's suggestion of ethnographic approach in nursing research to grasp the patient's point of view; his relation to life, his vision of phenomena of health and illness, curing practices, and ritual expression-"folk health system" in order for any health care to be relevant,[64] and Haggerty's "patient pursuit"[65] and Perkins need for "Aggressive and vigorous education"[66] all seem to agree with Fuchs' view that health level of people in developed countries today are related more to the genetic, environmental factors and life styles of people than the quantity or quality of health care.

Consumer-Centered health care concept express itself in various forms, beginning with the total control by consumer boards as indicated by some O.E.O. health projects, to the basic preliminary survey of health care needs including demographic,mortality, morbidity, and sociocultural data upon which the form, hours, location and the kinds of programs will eventually be built. Allied to this trend is the concept of continuity of natural life pattern as much as possible even at times in needs of health care. The sweeping emphasis on ambulatory health services in general, and family focused, various triage arrangements in geriatric, mental health and rehabilitative care, and some alternative care arrangements in maternity services are the examples.[67][68][69][70][71]

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61) Joseph T. English, Is the O.E.O. concept-the Neighborhood Health Conter-the Answer? Medicine in the Ghetto 1969, p. 262—6.

62) K.R. Lorig "Consumer-Controlled Nursing" Nursing Outlook 17 : 50, Sept.1969.

63) Dolores W. Echeveste, Hohn L. Schlacter, Marketing: A strategic Framework For Heallth Care Nursing Outlook, 22 : 377—81, June. 1974.

64) Rosella Schlotfeldt, Ethnogradhic Approach and Nursing Research:Symposium on Approaches to the Study of Nursing Questions and the Development of Nursing Science, Nursing Research, 21 : 484+Nov.-Dec. 1972.

65) Robert J. Haggerty, What Type of Medical Care Can or Should be Offered to the Urban Poor? Medicine in Ghetto 1969, p. 251—259.

66) Mary Rose Perkins, Does Availability of Health Services Ensure Their use? No. 22 : 496—8, Aug. 1974.

67) Joan L. Quinn, Triage: Cooridnated Home Care for the Elderly, Nursing Outlook, 23 : 570—3, Sept. 1975.

68) Katherine F. Shepard, Louise M. Barsotti, Family Focus-Transitional Health Care, Nursing Outlook 23 : 574—7, Aug. 1975.

69) Eunice K.M. Ernest, Mabel E. Forde, Maternity Care: An Attempt at an Alternative, Nursing Clinics of North America 10 : 241—9, June. 1975.

70) Sharon Schindler Rising, A Consumer-Oriented Nurse-Midwifery Service, Nursing Clinics of North America, 10 : 251—61, June. 1975.

71) Home Health Care Supported in House Committee Report, American Nurse, Vol. 8, No. 5, March 15, 1976.

2. Primary Care, Expansion of Roles, and Interdisciplinary Collaboration.

The term "Primary Care" has been defined in the Secretary's Report on Extending the Scope of Nursing Practice, U.S. Dept. of H.E.W. as: 1. A person's first contact in any given episode of illness with the health care system that leads to a decision of what must be done to help resolve his problem; and 2. the responsibility for the continuum of care, i.e., maintenance of health, evaluation and management of symptoms, and appropriate referrals. There are many other definitions of primary care, but all of them support the concept of long term health maintenance care for individuals and families through an ongoing relationship with one professional who evaluates their level of health and health problems, plan, provide and coordinate necessary health services, and make appropriate referrals for care in collaboration with the client and the health team members.

In response to health care crisis especially with notable primary care deficit, Silver and Ford launched a Pediatric Nurse Practitioner Program at the University of Colorado in 1965 as a means of extending primary health care services for children, and marked a beginning of a new era of collaboration and accountability in health pofessions. Various physician's assistant's programs and nurse practitioner programs following the pattern mushroomed and were all aiming at the education of primary health care personnel for the extension of health services to the underserved communities. Implicit in the expansion of primary care is the need for a change of roles and interdisciplinary collaboration among health professionals.

Neighbor urges that nursing should move actively to fill the gap in the health care system which was produced as the result of social cultural change saying that, "If, in this modern era of medical specialization, the nurse is the only person who has time to perceive the total patient, then, it follows that, she must assume authority and responsibility for diagnosis and treatment which is independent of the physician's authority and responsibility... perceiving and treating the total patient as the family doctor used to do is a desirable and perhaps imperative role for a nurse practitioner to assume." He further suggests that for the maximization of health care effectiveness, the nurse and physician should become a diagnostic and treatment team, and functionally, the responsibility of the physician and the nurse are the same-to diagnose, treat and cure. The difference is that "physician provides depth and the nurse provides scope."[72]

Mereness and Mussalem also saw a greater challenge and satisfying career for nurses through primary health care nurse practitioner role, and Wolford predicted that nurse practitioners as a "free lance nurse," will be able to offer individually tailored, personalized, continuous care in which they find security and solace when they are ill.[73] Humane, better quality care was also envisioned by Henderson as she predicted that nurses and physicians will be assistants to patients as the patients and their families assume a more dominent role in trying to maintain or regain health, live productively with a handicap, or die with dignity.[74] Emerging colleagueship between physicians and nurses were visualized and mapped by Pepplau and

72) Howard D. Neighbor, This I Believe About Nursing Education, Changing Perspectives of Nursing Practice, A.J.N. Comp.1971, p.133

73) Dorothy Mereness, Helen K. Mussallem, Helen Wolford, Expended Concepts of the Nursing Role, Changing Patterns of Nursing Practice. Compiled by Edith P. Lewis, A.J.N. Com. N.Y. 1971, p.85—104.

74) Virginia Henderson, Nursing in the Decade Ahead, Changing Patterns of Nursing Practice, p.170.

Thomstad et al.[75][76] It was also envisioned by Abdellah that as the nurse practitioner is recognized and accepted for her needed contributions to health care delivery system and as the degree of nurse autonomy increases, with her power to make decisions with the patient as a partner, there is increased hope of achieving improved health care for all Americans"[77]

In the midst of confusing role identity, Murphy presents her argument about the direction of role expansion for nursing delineating the conceptual difference between "Role extension" and "Role expansion." Role extension is defined as a unilateral lengthening process which would include "either carrying out the same functions in protracted contexts or elongating specific, already assumed functions to fill perceived gaps in the health care system." Most of the learning that occurs in this change process is situationally determined, such as in apprenticetype training by a role model that is most frequently a physician and the authority base from which the extended role of the nurse emanates is the physician who allows nurses to carry out some of his delegated functions. On the other hand, role expansion is defined as a spreading out or a diffusion process, a multidirectional change, a process not only to fill perceived gaps but also to project new components or systems of health care. The supportive knowledge for the expanded role of the nurse is theoretically based and obtained in a university context and the authority base is the theoretical and clinical knowledge that incorporates a broad spectrum of health care. Thus she concludes that role expansion is the way to pursuit for nursing.[78]

Today there are nurse practitioners with all different names according to education and practice. A nurse in an expanded role with a special education and experience gained through a recognized program beyond basic nursing education is the qualification for the name. Starting with Private Nurse Practitioners, Family Nurse Practitioner, Pediatric Nurse Practitioner, Nurse-Midwifery Practitioner and all other clinical area specialty nurse practitioners come under this category.

The editorial of Nursing Outlook, Feburary 1974, deals with the emerging concept of nurse practitioner. The common denominators in the concept were delineated as: 1. Oriented toward providing care for clients rather than services to institutions. She practices independently, or interdependently as the setting dictates-makes own decision, assumes responsibility and accountability for them, and is subjected to few if any hierachical restraints; 2. Maintains one-to-one relationship with her clients and sees them as part of the family-community constellation to which they belong; 3. She may or may not possess, or feel the need for physical assessment skills; to the degree that she uses them, she does so to enrich the data base for her nursing judgments, for the nurse practitioner is not practicing medicine, she is practicing nursing; 4. And to practice in this way, she has developed an appropriate, and for most nurses, new concept of herself and her nursing identity.[79]

The nurse practitioner concept and their role in extending health care service as described

75) Hildegard, Peplau, Nurses As Collectivity Must Take a Stand, A.J.N. 70 : 2123, Oct. 1970.

76) Beatrice Thomstad, Nicholas Cunninghasm, Barbara H. Kaplan, Changing the Rules of the Doctor-Nurse Game, Nursing Outlook, 23 : 422—27, July. 1975.

77) Fay G. Abdellah, Editorial Nurse Practitioner and Nursing Practice, American Journal of Public Health 66 : 245 March 1976

78) Juanita F. Murphy, Role Expansion or Role Extension, Nursing Forum 9 : 380—9, (No. 4) 1970.

79) Editorial: A Role by Any Name, Nursing Outlook, 22 : 89, Feb. 1974.

above however, is not new. We should be reminded of the fact that Frontier Nursing Service has long demonstrated nurse effectiveness in bringing health care to greater number of people in physician-poor community for over fifty years and public health nurses for that matter have served in similar capacity since World War I only without sanction. Roger argues that nurse-practitioner advocacy is only the game of name-a politicized euphemism.[80]

<국문초록>

지역사회에 기반을 둔 간호사업 : 그 배경과 실태에 관한 고찰

홍 여 신 · 이 선 자

간호사업은 1970년대 후반부터 이제까지의 병원중심—환자중심의 간호사업을 수행해 오다가 지역사회에 기반을 둔 간호사업인 건강간호사업으로 전환되기 시작하였다. 세계보건기구에서도 지역사회에 기반을 둔 간호사업인 일차건강관리사업을 중점적으로 지원하기 시작한 것이다. 이러한 역사적 전환의 배경과 실태에 관하여 문헌고찰을 하여 앞으로 국민건강사업 체계에 대한 논의에 참고자료가 되게 하고자 본 논문을 시도하였다.

본논문에서 얻어진 결과를 다음과 같이 요약한다.

고도의 과학문명의 발달과 물질적 풍요로 특징짓는 현대사회속에서도 인류의 건강문제는 영원히 충족되지 못한 상태로 대두되고 있는 실정이다. 전통적으로 60년대 중반까지는 의료지식 및 기계공업의 발달과 이를 뒷받침할 재정적 지원속에 세계적으로 치료의학분야에 획기적인 발전을 가져왔다. 다른 한편으로는 건강을 태생의 권리라고 규정하여 여러나라에서 사회보장제도로써 의료시혜의 균점을 위한 각가지 방도를 마련하기에 이르렀다. 그리하여 60년대말기부터 70년대로 넘어오면서 치료의학의 발달만으로는 의료수가가 앙등되어 모든 국민이 이용할 수 없을 뿐만 아니라 나아가서는 모든 국민의 건강문제를 해결하기는 어렵다는 사실을 발견하기 시작하였다. 또한 지역사회의 건강문제를 요인별로 따져보면 복잡하여 사회경제적, 문화적, 환경적, 유전적 제요인과도 밀접한 관계를 맺고 있기 때문에 신체적인 질병의 치료만이 지역사회 건강문제를 해결하는 길이 아님을 알게 되었다 그리고 지역사회의 건강문제를 해결하기 위해서는 일차보건의료사업에 중점을 두어 노력하는 것이 가장 합리적인 개선방안이라는 의견이 경험적으로 이론적으로 뒷받침되기 시작하였다. 이러한 사조는 지역사회 건강문제가 복잡한 것과 같이 그 접근방법에 있어서도 여러보건요원이 팀이 되어 일해야만 하며 그중에서도 간호팀의 활동이 중추적인 역할을 담당해야 한다고 여러 전문가들은 주장하고 있다. 따라서 앞으로의 간호사업의 방향은 지역사회에 기반을 둔 간호사업이 실시되어야만 국민건강문제 해결에 기여하게 될 것으로 고찰되었다.

80) Martha Roger Presentation at Teacher's college Spring 1976.

〈註〉 본 논문은 이번호에 이어 3,4월호에 계속 게재합니다.