Analyzing Your Health Delivery System

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INTRODUCTION

Delivering a talk on “Analyzing Your Health Delivery System” to a group of medical professional students is similar to delivering a talk on “Diagnosing Patients” to a group of pre-professional college students. I can’t possibly present and you can’t possibly absorb all of the relevant information at this time. In the first place many of the ideas and technical terms I will use will be completely new to some of you and some of them will be new to most of you. So I would like to make the purpose of this talk clear. The purpose is not to give you an instant education in health delivery system analysis or to make you an expert on your own health delivery system overnight. Rather, the first purpose is to introduce you to new perspectives for looking at your health delivery system, perhaps your society and perhaps even yourself. The second purpose is to give you enough in-depth introduction to health systems analysis so that years from now, when you face the problems we introduce, you will at least know that there exists an approach and a technology which may help you to solve them.

I plan to present a systematic method for studying your health delivery system. We will consider: 1-health problems, 2-health resources, 3-constraints upon the health delivery system, 4-organization of the system, 5-interaction of the system and society, and finally 6-the motivation, purposes and values of the system. This will be a simple skeleton which may be of help to you in your discussions, but you must vitalyze it with your knowledge of your own health delivery system.

Throughout my presentations will run the themes of inadequacy, accountability and the need for change.

HEALTH PROBLEMS

First, you should consider the health problems of your country quantitatively and qualitatively.

Pure quantitative health indexes indicate how bad the health problems are, and include an estimate of the Average Life Expectancy at Birth, the Crude Death Rate, the General Fertility Rate (number of births/year/number of women 15-44 years old) and the Crude Rate of Natural Increase (CRNI). This is pretty simple stuff, right? If we know these factors we can compare our country with some others, which we presume have the most advanced health standards in the world, to see how we shape up and just how far we have to go to be as good as they (e.g.: “the best”) are (Table 1).

Next we can look at some mixed-quantitative
and qualitative health indexes. They will not only give us some idea of how bad our situation is, but also they will start to give us some insight into what kind of health problems we have. The Infant Mortality Rate and the Maternal Mortality Rate give us some idea of the adequacy of medical care services, while the Children's Average Growth and Development Profile tells us something about the nutritional and social-economical status of our population, and the 1-4 year old Death Rate will reflect both the nutritional and socio-economical status of the population and also the effectiveness of the nation's preventive medicine services. (Table 2)

Now we recognize the patient is sick so let's diagnose the disease. which reminds me of the joke about the lady who told her eager, but inexperienced young physician, "Doctor, I hope you can treat what I have." To which the Doctor replied, "Lady, I hope you have what I treat."

Qualitative health indexes start to give us some understanding of why we have health problems. Knowledge of the 10 Most Common Cause of Death-for all ages, for infants and for 1-4 year old children-should allow any physician to start "treatment in the usual manner." (Table 3) If you are a little more sophisticated you might confirm your diagnosis with Disease Specific Morbidity Rates. But wait a minute, are our old medical standbys of more doctors, nurses, hospitals, vaccines, water systems, drugs, etc. appropriate? I don't think so. I think the health problems of our countries are more closely related to the Gross National Product per Capita (GNP/Capita), the Annual Rate of Change of the GNP/Capita, the distribution of the nation's wealth, the illiteracy rate, the human value system of the population, and the social-cultural-political-economic milieu than to any of these medical factors. Knowledge of these nonmedical, non-health indexes will give you the most accurate diagnosis of the etiology of your health problems.

This is way out! Now, I'm asking you medical students to become economists, sociologists, educators, and politicians in order to practice medicine on your community. Well,
### TABLE 3

#### 10 Most Common Causes of Death, All Ages

<table>
<thead>
<tr>
<th></th>
<th>Korea ('67) — Rate/10,000</th>
<th>Japan ('64) — Rate/10,000</th>
<th>U.S.A. ('64) — Rate/10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>4.4</td>
<td>17.2</td>
<td>31.3</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>3.6</td>
<td>10.7</td>
<td>15.1</td>
</tr>
<tr>
<td>Cerebro-vascular</td>
<td>2.6</td>
<td>6.2</td>
<td>10.4</td>
</tr>
<tr>
<td>Malignancies</td>
<td>2.6</td>
<td>5.2</td>
<td>10.4</td>
</tr>
<tr>
<td>Gastro-enteritis</td>
<td>1.4</td>
<td>4.1</td>
<td>3.6</td>
</tr>
<tr>
<td>Accidents</td>
<td>1.3</td>
<td>2.4</td>
<td>3.0</td>
</tr>
<tr>
<td>Heart disease</td>
<td>1.2</td>
<td>2.3</td>
<td>Newborn infection others</td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td>1.9</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td>1.5</td>
<td>Senility</td>
</tr>
<tr>
<td>Bronchitis</td>
<td></td>
<td>1.4</td>
<td>Birth injuries</td>
</tr>
</tbody>
</table>

#### 10 Most Common Causes of Death, Infants

<table>
<thead>
<tr>
<th></th>
<th>Korea ('65) — %</th>
<th>U.S.A. ('61) — %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prematurity</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Tetanus</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Diarrhea &amp; enteritis</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Birth injury</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Convulsions</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Measles</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Dysentery</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

#### Most Common Causes of Death, 1-4 y.o. Children

<table>
<thead>
<tr>
<th></th>
<th>Korea ('65) — %</th>
<th>U.S.A. ('83) — %</th>
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</thead>
<tbody>
<tr>
<td>Infections</td>
<td>56</td>
<td>31</td>
</tr>
<tr>
<td>(Encephalitis)</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td>(Diarrhea &amp; Enteritis)</td>
<td>(11)</td>
<td></td>
</tr>
<tr>
<td>(Measles)</td>
<td>(10)</td>
<td></td>
</tr>
<tr>
<td>(Pertussis)</td>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>(Meningitis)</td>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>Accidents</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>5</td>
<td>11</td>
</tr>
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that is what Community Medicine is all about. The personal physician had to progressively acquire the skill of an anatomist, physiologists, pharmacologist, biochemist and psychologist to adequately treat his patient. Similarly, the community physician is going to have to broaden his academic horizons to incorporate “foreign” disciplines if he is going to treat the community.

HEALTH SYSTEM RESOURCES

The focus for health delivery system resource analysis has always been upon the medical resources available. These are only one component of the health delivery system; although, an extremely important component. The bulk of the health delivery resources are either only peripherally related to medicine or non-medical.

To comprehend your country’s medical resource position you should look at the ratio of doctors, nurses, pharmacists, other medical personnel, hospital beds and other medical facilities to the population, and their production and attrition rates. (Table 4)

Beyond this you should be familiar with their qualifications in the light of the health needs of your country. The money your country spends for health services is an important resource, so you should determine the total amount spent per capita, as well as who spends it (government, private, charity, etc.), what it is spent for (curative medicine, preventive medicine, public health etc.) and the substances purchased (drugs, services, buildings, etc.): although, these later factors are more properly considered under the discussion of Organization and Process. (Table 5)

Peripherally related resources include such things as social caseworkers, teachers, agriculturists, plumbers, food handlers, civil engineers, politicians, bureaucrats, and countless

<table>
<thead>
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<th>TABLE 4</th>
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<tbody>
<tr>
<td>Medical Resources</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Korea('71)</td>
</tr>
<tr>
<td>Population/Doctor</td>
</tr>
<tr>
<td>Population/Nurse</td>
</tr>
<tr>
<td>Population/Hospital bed</td>
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<table>
<thead>
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<th>TABLE 5</th>
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<tbody>
<tr>
<td>Health Resources</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Korea('69)</td>
</tr>
<tr>
<td>Total health expenditures/capita (US$)</td>
</tr>
<tr>
<td>—% of GNP</td>
</tr>
<tr>
<td>Government health exp./capita (US$)</td>
</tr>
<tr>
<td>—% of GNP/Budget</td>
</tr>
<tr>
<td>GNP/capita (US$)</td>
</tr>
<tr>
<td>Annual rate of increase GNP/capita</td>
</tr>
<tr>
<td>Literacy rate</td>
</tr>
</tbody>
</table>
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others, who's primary interests and primary responsibilities are not in the realm of the health delivery system, but who's daily activities nevertheless directly affect the health of the population. Are there enough of these people well qualified to fulfill their role as it influences health? Do they even understand what, when, where, how and why part of their work affects health? Do the health professionals? Does anyone care?

Non-medical resources of the country directly influencing the health delivery system include the transportation, communication, economic, education and government systems. Is the GNP/Capita, its annual rate of change, and the distribution of wealth a problem or a resource? How about the CRNI? The literacy rate is obviously a resource, but it is only a complement of the problem illiteracy rate. Do you understand how these factors affect you and the health of your country? Is your understanding of them sufficient to allow you to attempt to influence them for the improvement of your people's health?

"Wait a minute.", you may say at this point, "What about the nonwestern medical practitioners as resources?" I will reply, "What about them as problems or constraints?" To be realistic their effect upon all three areas must be considered. They are there and they provide "health care" to part of the population. How do their activities balance out? Are they primarily beneficial or detrimental? Could anything be done to make them more beneficial? I try to take a very pragmatic attitude toward them. First, they are satisfying the desire for treatment of many people whom western medical care has failed or who have inconsequential or self-resolving illnesses. Second, although some of their actions may be pragmatically modified; their practice essentially is based upon belief in a system, similar to our belief in the scientific method, and like ours held with the intensity of a religion. Third, I believe integration of the two systems can be carried out only with a tremendous expenditure of scarce health resources. Nor do I think either group will enter into an integration scheme honestly willing to assume the values and belief system of the other, but each will expect to assimilate the other group into their own system.

Therefore, I suggest evaluating the traditional practitioners' total impact by utilization rates and outcomes, as closely as possible, and then leaving them alone until either their total impact upon society is demonstratively negative or you have a surplus of health resources which can not be employed along more productive routes for improving health care.

CONSTRAINTS ON THE HEALTH DELIVERY SYSTEM

We have just said that problems and resources are intimately related, often opposite sides of the same coin. This is even more true of resources and constraints. Probably the most restrictive constraints health planners imagine faces their health delivery system is the lack of resources. If by "resources" they include such resources as: 1-an intelligent, well informed, public serving, national leadership and bureaucracy; 2-other person centered medical and para-medical professions; and 3-a flawless system for the delivery of health services; then I agree. However, they usually only include money, medical personnel and medical facilities as resources. As you can guess, my approach is slightly different.

The lack of traditional medical resources is a significant real constraint, but more significant constraints are the organization or non-organization of the system, the processes
within the system, its interaction with the society, and the motivation, purpose and values of the system. These constraints are so important we will consider them separately, but they deserve much more attention than this superficial introduction.

**Organization**

Our discussion of problems, resources and constraints disclosed that they were intimately related and that our presentation of them separately was artificial. Similarly, the divisions into organization, internal processes, interaction with society, and motivation, purposes and values is artificial and arbitrary. However, this type of compartmentalization of life experiences into the smallest possible units is a necessary process for analysis and "understanding" inherent in Western logic and medicine. Those of you who can understand medical care systems intuitively and ubiquitous will be bored or even confused by my piece-meal approach. Those of you who share my mental limitations may profit from this exercise. But I can't even guarantee that.

There are too many instances in medicine where countless agonizing hours of piece-meal research to solve a problem have been rendered worthless because one fortuitous incisive breakthrough has solved the problem and antiquated previous efforts.

When considering the organization of your country's health delivery system remember that there may be a great gap between the ideal, desired, planned or stated system and the actual system. Although, health planners and educators speak idealistically about the fusion of public health, preventive medicine and curative medicine, it is not common for significant fusion to occur. Therefore, you will probably have to separately consider the organization of the curative medical system, the preventive medical system and the public health system.

The most important factor influencing the organization of the system is its control, and control is synonymous with financing. Who actually controls the money flowing through the system and how does it flow? An understanding of the health delivery system from this aspect is an understanding of where the power lies, especially where the thrust for change is apt to be most effective.

For instance, in the laissez faire, free enterprise, private practice system of curative medicine, popular in the Western World at the turn of this century, the money was under joint control of the individual patient and the individual doctor. Therefore, a highly individualistic, personal oriented, quack ridden system for delivering medical care evolved. The emphasis was on giving the individual who could afford it the medical care he and his doctor wanted and to let others take care of their own problems. At the other extreme of the financial control spectrum, we have the Russia Communist example during the Stalin era. At that time the state highly centralized and rigorously controlled all access to money. A physician had to work for the state and practice as the state directed. The state was pre-eminate, the rights of individuals were secondary and a doctor's primary function was to keep the workers toiling for the state, like a mechanic oiling a machine. In this system the patient and the physician became antagonist. The patient tried to get away with as much as he could, and the doctor had to protect himself by pushing the patient as far as and as hard as he could. Fortunately, today most systems of medical care are somewhere between these two extremes. This is the schematic representation:
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The spectrum of financial control of medical services

<table>
<thead>
<tr>
<th>Financial arrangement</th>
<th>Central state control</th>
<th>Decentralized state control</th>
<th>Pluralistic state and institution control</th>
<th>State supervised institution controlled</th>
<th>Complete laissez faire</th>
</tr>
</thead>
<tbody>
<tr>
<td>An example</td>
<td>Communist Russia Under Stalin</td>
<td>Communist Yugoslavia Today</td>
<td>Socialist England Today</td>
<td>?Late 20th Century U.S.</td>
<td>Mid 20th Century U.S.</td>
</tr>
<tr>
<td>Effect upon the patient</td>
<td>Poor</td>
<td>Variable</td>
<td>Fair</td>
<td>?</td>
<td>Fair</td>
</tr>
<tr>
<td>Effect upon society</td>
<td>Poor</td>
<td>Fair</td>
<td>Good</td>
<td>?</td>
<td>Variable</td>
</tr>
<tr>
<td>Effect upon physicians</td>
<td>Poor</td>
<td>Variable</td>
<td>Poor</td>
<td>?</td>
<td>Good</td>
</tr>
</tbody>
</table>

Probably your country’s medical care system does not fit exactly into any of these schematic cells, but you should be able to locate it somewhere along the line between the two extremes. Also, you will probably find that the different components of your health delivery system are located at different places in the financial-control spectrum. Traditionally Public Health and Preventive Medicine have been state functions. Usually they are located to the left of curative medical services, which more often are considered personal business. There are many other examples of the various methods of financial arrangements and many of them with similar financial arrangements have entirely different effects upon the patient, society and physicians. This is because financial control; although, it is one of the most crucial factors affecting the quality of health services, is not the only determinant of the outcome of health care.

The institutional structures within the health delivery system are the organizational structures through which power, money, communication, decisions and people flow. Institutions are found serving state, professional, public business, international, foreign government, indigenous and foreign religious, voluntary and involuntary health delivery system interests. An understanding of their individual hierarchies and politics, and their relative roles and political relations is essential if you want to understand and influence your country’s health delivery system.

PROCESS WITHIN THE HEALTH DELIVERY SYSTEM

Those of you who have not yet given in to sleep, being overcome by the apparent trivial I am presenting, or given up in anger, frustration or hopeless confusion may realize that by introducing an analysis of the processes occurring within the system I am now asking you to incorporate the skills of a systems analysts into your already expanded prerequisites for the practice of medicine.

For our purposes, we should consider the flow of professional personnel, the decision making processes, and the flow of patients within the system. We could also consider the flow of money, but that would be redundant, and the flow of facilities, equipment and supplies, but that is really only a secondary dependent variable not worth independent analysis.
First, the flow of professional personnel I am speaking of professional personnel in the expanded sense of all members of the health services career team. How do they enter the system? Is there active recruitment? Who is it aimed at recruiting? Is there a screening system? What standards does it operate by? Who operates it? Is it both quantitative and qualitative? Is it accidental or planned? What are the assurances it is operating in the interests of the health delivery system?

After personnel enter the system, what is the educational process? Is the education relevant to the needs of the health delivery system? Who is in a position to insure this? Who directs the education system? What formal and informal channels for mutual support and evaluation exist between the educational and other components of the health delivery system? Are there mechanisms for self-evaluation within the education system? Are they functioning? Finally, and most importantly, what kind of models are the students exposed to? Are the teachers models of what you want the education system to produce?

When the professional leaves the formal education system what viable options are available for his employment? Which are most important according to the priorities of the health delivery system? Which are the most attractive as viewed by the professional? Do promotions and awards go to those most serving society or themselves? Who is honored and payed the most; the neurosurgeon doing 3 operations a week, the pediatrician seeing 300 patients a week or the public health physician battling bureaucrats, politicians and public apathy for the health of 30,000,000 people? Do most careers lead to an early “dead-end”? Where can a 28 year old chief of nursing service go next?

What can be done to make the most important options also the most attractive? Is anyone in your country concerned about this? Are you? What is the career hierarchial structure of the health delivery system? What is the basis for the distribution of personnel? What kind of politics is going on within the system? Is it healthy or un-healthy? What in-service-educational opportunities are available? What frustrations are personnel meeting? Who is working on personnel problems? Anyone?

Finally, who is dropping out of the system? Why? Is the “brain drain” really the result of “greener grass on the other side of the fence”, or is it the result of no grass or bitter grass on this side? Do the working and living conditions in your country encourage or discourage health system personnel? Can the adverse factors be identified and corrected? Is anyone trying?

Second, we should attempt to understand the decision making processes of the health delivery system. Let’s start at the top. What is the relationship of society’s power structure and decision making process to the system? What priority is assigned to health? On what basis? Does this priority accurately reflect the people’s priority ranking? Who knows? Who cares?

Within the health delivery system, where and how and by whom are decisions made? Are there publicly sanctioned goals and priorities? Are the people making decisions technically competent or are they chosen primarily by seniority, politics or graft? Is all of the available information considered by the decision makers? Are decisions made at the most appropriate level? That is, as close as possible to, or by, those with power to implement them? If the implementators or operators are
not actually making the decisions, are there
two-way channels of communication function-
ing to allow them to know that their opinions
count in the decision making processes?

What is the balance between local autonomy,
regionalization and centralization? What is the
balance of professional, lay and political coop-
eration or domination? Are the doctors the
only health professionals with an effective
voice? What role do the clients (those receiving
health services) have in the decision making
processes? Is anyone listening to them?

Are there pseudo-decision makers in the
health delivery system? That is “health plan-
ers” stuck off in a corner somewhere, power-
less and functionless? Are they completely
autistic or can they be salvaged and put to
work?

From the preceding you undoubtedly recog-
nize that I consider the decision making
processes in the health delivery system similar
to life. Life is an essential part of every cell
in the body, yet some cells and organs are
more essential to the body’s life than others.
Likewise, some decision making processes must
be more centrally located than others, but a
meaningful role in the decision making proces-
ses is necessary for every component of the
system.

Finally, we must analyze the flow of pa-
ients as part of the process of our health
delivery system. First, let’s consider their
entry into the system. How accessible is the
system in terms of distribution, transportation,
communication, economics and geography?
What educational and social barriers exist?
When and how can a man working from
sun-up to sun-down at a subsistence level get
medical care? In other words, are the health
services the patients need provided when,
where and how they can be optimally utilized?

After the patient enters the system, how is
he treated? As a disease, as a beneficiary, or
as an equal human being? How is he used by
the health service personnel and institutions?
Primarily for their benefit or his benefit?
Does the health delivery system really affect
his health? Beneficially or adversely? It has
been stated that prior to 1910 there was only
a 50:50 chance that the average patient
would receive more benefit than harm from
a visit to the average physician in the United
States. Today, I estimate there is about a 83
: 17 chance that the average patient would
receive more benefit than harm from a visit
to the average physician. (Patient visits can
roughly be divided as: in 70% the net effect
of treatment is inconsequential, in 25% it is
beneficial, and in 5% it is detrimental.) What
are the odds in your country?

Lastly, what is the total impact of the
health delivery system upon the patient? Even
if the medical treatment is a success, in terms
of his health, is it an economic and social
disaster, because of the excessive burden of
the cost? Can the average person in your
country afford to share in your health delivery
system? How does your health insurance
system operate? Who operates it? In who’s
interest? Do you even have a health insurance
system?

INTERACTION OF THE HEALTH DELIVERY
SYSTEM AND SOCIETY

Although, the interaction of the health deli-
very system and society has been an integral
part of many of the previously considered
factors, it deserves a separate attempted anal-
ysis. This can be done by first considering
the health delivery system as a product of
society and then considering its impact upon
The health delivery systems existing around the world are the products of complex interactions of the religious, ethical, social, political, economic and technical history of man. As you walk through the streets of Seoul you see many small one family stalls, independently selling the same products side-by-side. Whereas in the United States the rule is supermarkets and all-inclusive discount or department stores. Similarly, we find most Korean physicians practicing medicine in complete isolation; attempting to deliver, or at least to make the patient think he is delivering, complete medical care by himself in his private “hospital.” Whereas in the U.S. the rule is partnerships group practice and staff appointments to community hospitals. How far can we expect the health delivery system to differ from the norms of its society?

I think we should expect the health delivery system, or at least its aspirations to rise to the level of universal or international standards. No single nation has a monopoly on medical research or health services excellence. Fortunately, the rapidly expanding medical technology demands international communication in depth. This communication presents the opportunity for adoption of more than technical information, but also for adoption of a universal health care value system, and an opportunity to informally hold medical representatives of various peoples personally accountable for their country’s health delivery system. Are you willing to assume personal accountability for your country’s health delivery system?

What is the net impact of your health delivery system upon your society? Is it improving the general society, or is it another factor increasing social unrest and discontent through its unjust catering to a selfish minority who monopolize most of the country’s resources? This is not an isolated problem, but one with social ramifications which we as health professionals must tackle constructively.

If we don’t create our own positive evaluation (Evolutionary change through peaceful means, but with the speed and completeness of a revolution,) then we must accept the inevitable consequences.

**MOTIVATION, PURPOSES AND VALUES**

The motivation, purposes and values of the health delivery system are also acquired from society, with the leavening of the international health “ethic”. If you are going to understand your health delivery system, you must understand its motivation, purposes and values. It will be impossible for you to change your system from within without understanding them.

When considering motivation, purposes and values remember that the overt motivations, purposes, and values probably are not the most important ones. There are always covert motivations purposes and values, which are seldom discussed and may be so deeply internalized that they are not recognized by anyone. However, these covert motivations, purposes and values can be discovered by trained observation. “Actions speak louder than words” but like words you have to study the language.

What are the priorities and values of the institutions and individuals within the system? Are they self-serving only? Are they identified with greater interesting? If so, whose greater interests, the profession’s, the system’s, the society’s, or man’s?
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What motivates the system or makes it go? Is it simply running mindlessly on because it is there; taking the course of least resistance? Why do people enter the health services professions? Desire for self-improvement or desire for Man’s improvement or both? Does the system tend to extinguish or to reinforce a desire to help Man? Does the system tend to extinguish or reward self-serving?

Well, I have just done it again; added another dimension to your educational prerequisites—anthropology. But the dictionary defines anthropology as “the science of the study of man”, and that sounds exactly like my definition of medicine.

CONCLUSIONS

There are eight conclusions to be drawn from this introduction to analyzing your health delivery system.

First, your practice of community medicine requires the skills of economics, sociology, education, politics, systems analysis and anthropology, as well as the traditional skills of curative medicine, preventive medicine and public health.

Second, the situation usually determines whether a particular component of the system is a health resource, problem or constraint, but in any case you must understand its relationship to your health delivery system before you can deal with it effectively.

Third, many health delivery system problems, resources and constraints would not be traditionally classified as “medical.” Although, “medical” problems, resources and constraints must receive their due emphasis, you can not afford to overlook the “non-medical” ones which may be the most critical factors for your situation.

Fourth, planned change is impossible from within your system without understanding its organization, processes and interaction with society. One of the most essential of these is the flow of money or power through the system.

Fifth, the motives, purposes and values of the health care system provide its life force; heart, mind and soul. Physician understand yourself and your health delivery system if you expect to improve them.

Sixth, your health delivery system is a product of its society, but because of its unique dependance upon international nature it can subscribe to a different value system—that of the international health community.

Seventh, your health delivery system must assume its share of responsibility and accountability for the society it supports.

Eighth, you must assume your share of responsibility and accountability for your health delivery system.

REFERENCES


e-Estimated From various available information


k-Monthly Statistics of Korea, Vol. 8, 1970, E.P.B.
l-Seoul Vital & Health Statistis-Analytical Studies, S. Series 3 No. 6 USDHEW, 1967
q-Clark DW, MacMahon, B. Preventive Medicine, Little Brown, 1967, Boston.