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Timeliness and Equity of Access

Patient satisfaction with a health care system has been recognized as an independent value and goal. It is also an important means of bringing about utilization that professionals think is good for health. In working out the essential features of a national system the concept of equitable access has been seen as critical. Equity involves the idea that class, sex, ethnicity, and place of residence should not determine access and that a poor person, for example, should not have to be in extreme distress to receive help while a richer person is not so constrained. At the same time, it makes economic sense for system capacity to be allocated to those who need it. However, who determines need? Timing helps shed light on this question, and the Steinwachs-Yaffe study in the current issue of the Journal helps shed light on timing, although it raises as many questions as it answers.[1] It seems, from this pilot study, that providers think that getting care when needed affects the medical, functional, and psychological aspects of illness. It is not surprising that the perspective of providers is not necessarily the same as patients' definition of need.

To minimize "delay" as seen by providers, consumers would be best served by a system that undertook to change their care-seeking behavior. A regular source of care can help accomplish this because it offers the opportunity to instruct patients effectively as to how to respond prudently to their body states. It also simplifies the psychological task of gaining access on a given occasion, although it may be harder to see a particular practitioner than to get access to "care" in general; a regular source of care also means that a visit can be shorter. Since certain patients may be more psychologically equipped to form a satisfactory relation resulting in a regular source, what does the system do to help the less advantaged patients? Every system has to undo negative learning, resulting from bad experiences, which make a patient reluctant to seek care until distress and urgency override these attitudes. Delay may result from preoccupation with stressful or exhausting life events or from preoccupation with other illnesses (Fink has shown this for breast cancer detection programs).[2]

To minimize unneeded use of care, systems would do well to insure that anxiety is reduced by care even when the providers think that care was unnecessary. Does the system have alternative means of handling anxiety? Phone calls usually help, but which doctors can be reached by phone? Are switchboard hours limited so that patients must wait to make any kind of contact? Are physicians substitutes who can alleviate anxiety and offer concrete guidance part of the structure?

Factors in the context of a given delivery system may be conducive to anxiety. Radiation exposure from diagnostic tests is rarely monitored. Little appears to have been said about the tenacious memories and fears of older patients in relation to diseases and complications that were familiar in their earlier years but are not even imagined by the professionals who see these patients today. Additionally, latent effects of treatment recognized long after the original events (as with diethylstilbestrol in pregnancy) provide fuel to anxiety at all ages. Therapeutic controversies are no less lively today than 250 years ago when vaccination against smallpox was not yet in, and bleeding not yet out. Current susceptibility of physicians to brand-name drug

promotion remains an obvious feature of office practice. Patients may be anxious as to what will happen if they *do* seek care as well as if they *don't*.

Organizational features, such as appointment hours limited to times that conflict with work or home duties, may also be significant. Revising such features may be more effective if allowance is made for patient attitudes and circumstances. Assessing timeliness helps provide feedback on the effectiveness of efforts to wipe out delay.

However, the providers' evaluation has shortcomings. It does not really see "need" as the patient sees it. The predicted medical effects of timing have to be validated after an appropriate lapse of time (longer than one week).* Furthermore, the totality of the system must be taken into consideration. Timeliness in regular departments is not independent of walk-in opportunities in the same facility, telephone arrangements, etc.**

*Measurement of this type would require careful sorting of patients by multiple system disease, severity and other medical and social/psychological characteristics.

**Access as perceived by patients has dimensions that may not be encompassed in having a regular source of care.

The analysis of timing of care reported in this issue of the Journal[1] is based on a white population with above-average income. Do other population groups interact with health care systems in the same way and for the same reasons? It is time to find out, and to use the findings to improve health care delivery.

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The Environmentalist's Challenge

It is barely 16 years since Rachel Carson's *Silent Spring*[1] initiated a serious concern for the environmental impact of our commercial and industrial activities. The immediate response in most quarters was that this book overstated a relatively small problem. We have come to learn, however, that the warning was correct. The late 1960s saw the development of a popular national effort, culminating in Earth Day, which called attention to the need for a public commitment to a safe and healthy environment. Althought some saw this as a passing phase, the reemergence of popular protest against nuclear power and even high power transmission lines has gained a growing coalition of young and old, liberal and conservative calling for the preservation of the environment.

One of the benefactors of these developments has been the environmental scientist. New federal and private monies have been committed to support teaching programs and innovative approaches to problem solving. Much regulatory legislation has been passed. Some is directed to the control of existing sources of pollution; some is designed to prevent the introduction of new sources.

Observing these developments, people interested in environmental quality have been pleased by the emphasis on the preparation and consideration of environmental impact statements before the launching of new governmental programs. They have watched with some satisfaction the reduction in automobile and industrial pollution, even if the process has been frustratingly slow. They have even been surprised to see the development of evidence which suggests that increased pollution control may on balance create new jobs or save money, thus at times countering spurious economic arguments propounded by some polluters.

But scientists addressing environmental problems are being faced with second-order problems they may have hoped to avoid. For example, it seemed eminently reasonable to prevent atmospheric lead pollution by phasing out tetraethyl lead as a component of gasolone. The fight was a long one but eventually a successful one—phasing out has begun. Part of the problem, however, continues, as presented in the article in this issue by Joselow, et al.[2] The authors report that one of the replacements for organic lead has been organic manganese. Using methods similar to those characterizing pollution by lead from automobiles and its absorption by human beings, the investigation suggests a new problem. Manganese appears to be distributed in a manner similar to lead and in direct relation to traffic density. Unfortunately, the health effects of manganese are relatively poorly understood. Levels encountered in certain industrial settings are known to result in alterations in psychological and neurological function. But no data are available on low level, long-term exposure, especially in the general population.

The hazards of substitution are not new to environmental scientists. Inevitably judgments based on imperfect infor-