2. Given that today's youth have significantly higher percentages of body fat compared with the youth of 20 years ago, what is the impact of this increase on health status?
3. We know that in order to excel in academic settings, students must be healthy, alert, and fit. These characteristics allow students to concentrate on their classwork without the distractions of fatigue, illness, and discomfort. The problem that we face, however, during a "back to basics" movement in American education, is how to convince parents and school administrators alike that the skills acquired in health and physical education programs are also basic educational skills.

Though much has been accomplished in the National Children and Youth Fitness Study, the biggest challenges lie ahead. One priority is to duplicate the study on children in kindergarten through 4th grade. These youngsters often participate in physical activities without the advantage of professional guidance and support. Part of providing them with better guidance is obtaining baseline information for program planning purposes.

We must also do our best to make these data available for examination, subsequent analysis, and interpretation by members of professional physical education organizations, researchers, practitioners, school administrators, and parents. It is only after intense scrutiny of the data from a great many perspectives that studies like these can lead to enhanced fitness programs for American children and youth and the attainment of the 1990 objectives for exercise and fitness.

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Community-Oriented Primary Care: a Promising Innovation in Primary Care

The rising costs of health care have focused increasing attention on methods to improve the cost effectiveness of care. Because the costs of care are centered largely in the procedure-oriented activities of both hospital and outpatient specialty care, a renewed interest has emerged in primary care as a strategy to improve health outcomes at less cost. Primary care may be an important locus where modern medical technological capabilities can be effectively used to fulfill the health care needs of the population.

A recent report by the Institute of Medicine (IOM) concluded that community-oriented primary care (COPC) may be an important variation of the primary care model (*1*); COPC can be characterized as the use of epidemiologic and clinical skills in a complementary fashion to tailor a primary care program to the particular health needs of a defined community. The principles of COPC can be incorporated in a variety of forms of medical practice that define a target population and systematically identify and address its major health problems.

An operational model of COPC was developed for the IOM study based on three elements—a primary care practice, a defined population, and a process to address the major health problems of the community. This process is iterative and consists of four discrete functional steps: (*a*) defining and characterizing the community, (*b*) identifying the community's health problems, (*c*) modifying the health care program to address priority problems, and (*d*) monitoring the effectiveness of the program modifications. The model does not constrain the manner in which the practitioners of the community are organized or the manner by which the cost of providing the primary care is met, directly or indirectly, by the patient or patient groups. Nonetheless, the model, as delineated, does preclude defining a community simply as the collectivity of a physician's active patients, even though applying the COPC process to an active patient population might promote excellent primary care.

While COPC clearly is not the prevailing mode of primary care practice in the United States, the IOM report includes seven case studies in which the major elements of the COPC model were in place. Of particular importance is the presence of elements of COPC in practice settings with different organizational structures and mechanisms of financing. It appears that COPC is not by nature limited to publicly funded programs that address underserved populations; it can find expression

in the private sector as well. However, it is also apparent that environmental factors have a great deal of influence on the particular form of COPC that evolves. Of these, the organization of financing appears to be the most critical. If fee-for-service is the predominant source of revenue base, the practice has less flexibility to undertake COPC activities and must rely heavily on cooperation with other health programs in the community.

From a cost-containment perspective, COPC has considerable theoretical appeal. While there are up-front costs associated with the quantitative activities of COPC, these costs do not have a linear relationship to the size of the target population; therefore, in larger systems an economy of scale may be realized. Although the practice of COPC does not advocate withholding services, the iterative nature of monitoring effectiveness could lead to less emphasis on services and programs with little or no demonstrable impact. If successful, the process of identifying health problems with high priority and targeting effective interventions at those persons in the population at highest risk could lead not only to improved health status, but also to a decreased need, and hence decreased cost, of future health care. Yet, it is not entirely clear that the current mainstream of health care financing provides strong incentives to decrease future costs of care. In a fee-for-service setting, reduction in the future need for care means a reduction in future revenue, while in an HMO, the patients who receive the benefits of a COPC approach may be disenrolled by the time future health care costs are averted.

Before COPC can be widely adopted and integrated into the mainstream of the health care system of this country, a margin of impact not achievable by orthodox primary care must be demonstrated. The achievement of that impact at a reasonable marginal cost must also be shown. In its study, the IOM committee found no fully operational COPC models and was unable to generate new data to examine the marginal costs and impact of COPC. This task remains to be done, but the model proposed in the IOM study gives substance to the concept and provides a framework within which to develop the techniques of COPC and to test the impact of its components.

The tools and techniques necessary for the COPC functions are drawn from the concepts and quantitative methods of demography, epidemiology, and evaluation research. While these methods have been developed and are widely used within their respective disciplines, they have not been adapted for application in the busy primary care setting. This developmental task will require the combined efforts of practitioners and researchers, and it is a critical step in applying the model to the system of primary care of this country.

With the availability of appropriate tools, the components of the COPC model need to be rigorously tested for feasibility, cost, and impact in several health care settings. The research design must accommodate the near-term costs of the COPC activities and the relatively longer term effect, measured as an increase in the health status of the community and a decreased future need for health care. In the meantime, those practices currently engaged in COPC activities should be encouraged to continue their efforts and, especially, to measure and document their costs and impacts.

An earlier report from the IOM has defined primary care as an array of health services that are accessible, comprehensive, continuous, coordinated, and accountable (*2*)—attributes that have been difficult to conceptualize and achieve in the absence of a defined target population. Community-oriented primary care provides the substrate within which these attributes assume a definite dimension and relevance. COPC offers a framework in which a denominator population can be systematically addressed and within which concern for cost-containment becomes compatible with a concern for improving the quality and appropriate accessibility of health care services. The IOM study demonstrates the applicability of the COPC model in many health care settings of the United States, but the extent to which this form of primary care practice will result in additional improvements in health status, and at what cost, remain unanswered questions. However, the appeal of the concept and its partial demonstration in a variety of practice settings argue strongly that the potential of COPC must be vigorously explored.

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