as the rendering of professional services by several members of the health care disciplines in a unified structure designed for patient control and operational efficiency. All too often, group practice is applied to define the situation in which several practitioners share a professional building but their contact, one with the other, is limited. Essentially, this latter situation is nothing more than several practitioners occupying quarters in the same building. The important and essential element in true group practice is that the patient is subjected to a multi-disciplined approach for the professional services which he receives. The term group practice connotes that the patients who receive its professional services are able to, and do, in fact, pay for those services. Thus, with the exception of the factor of economics, it may be said that there are striking similarities between a clinic and a group practice. The latter, in its development as a potent present force in the administration of health services, is considered a consequence of the institutional concept of the clinic applied to patients in other than the indigent group.

One further term is worthy of definition in this discussion. Health center has had many varied meanings. Frequently it was used to designate a hospital complex or a clinical complex applied broadly to community health problems, both therapeutic and preventive. Oftentimes, one aspect of a community health problem had its organizational care in a health center. The New York Milk Committee in the field of child health and the experimental New York City Department of Health Lower East Side health center program for tuberculosis (by Commissioner S. S. Goldwater) are outstanding examples. As the levels of mass health care steadily improved in this country during the last four decades, the health center concept was altered. In effect, the resulting benefits of coordinated and organized solution to the health conditions of a large segment of a community in the low income or indigent groupings has been extended toward the concept of group practice. The Des Moines Health Center (Iowa) and the Judson Health Center (New York) are early (c. 1920) organizations of group practice applied to community or large district populations providing comprehensive health services, on an out-patient basis, under the aegis of a formed organization structure and with professional services of physicians, dentists, optometrists, nurses, social workers, etc., on a part-time or full-time salaried basis.

Important as part of the Judson Health Center program was an extensive supervised and integrated home care program as a vital adjunct to the center visits. In his discussion of the early history of the Judson Health Center, Davis[3] speaks of visits to the "clinic" as well as home visits. One must conclude that while that medical historian took great pains to proclaim the separateness of structure and function of the health center concept, he repeatedly lapsed into paragraphs which were convincing to the reader that the health center (the rose by another name) was a broader manifestation of the institutional concept of the clinic. One of its chief differences is that it more broadly applies itself to the health needs of the community. A second, and perhaps more important difference is the degree of centralization of the record system. In a single type of administrative unit, there exists centralized patient record control. Most clinics (as well as the Judson Health Center) maintain central record function. Where the health center is a federate type comprising many social welfare, civic and health groups, the record system is decentralized. Clearly, the former produced coordinated technical and health information and has withstood the test of time.

Socio-Economic Trends in Health Care

Specialists in public health agree that the social institutions, as they have been known in the past, are now witness to a broad based sociological change as they pertain to the concepts of the administration of health services.[4] This is, in part, a reflection of changes in national social attitudes and, at the same time, the result of great advances in the health sciences with their attendant niagara of technical complexities. For, indeed, the private practitioner in "solo" type practice, who was the direct participant in the "barter" for professional services with the patient whom he served, is representative of a theme which is on the wane. It is a situation which is being further modified daily.

The three main forces or trends in health care may be identified as prepayment, insurance underwriting and the intervention of the so-called "third party" and, finally, the trend toward centralization of facilities. Group practice is an expression of this latter movement. Any discussion of that form or environment within which health services are rendered should be understood in terms of its development, its relationship with the past and the reasons for the present state. While it is beyond the scope of this paper to concern itself with the historical and socio-economic forces which have blended to produce these