Jerome L. Schwartz

Early Histories of Selected Neighborhood Health Centers

In 1965 a study was conducted of a group of indigent patients at the Monterey County Hospital in Salinas, California.[1] The patients came from the southern part of the county, in and around King City. It was found that most of the hospital's clinics opened at 8 a.m., and that in order to attend the clinic, the patient would often have to start on his journey at 1 a.m., boarding a Greyhound bus for the one-hour trip to Salinas. He would then sit up the balance of the night, waiting for the clinic to open. Even if he were seen early in the morning, he still had to wait for a bus back, as the first bus for King City did not leave until afternoon.

Traveling long distances for care, as these patients—mostly Mexican-Americans—had to do, was difficult and accounted for infrequent pediatric care, minimal visits for obstetrical services, and restricted health care to crisis situations. Even when an automobile was available, it often meant that the father had to forfeit a day's wages and pack the whole family into the car in order to bring a sick child or pregnant wife for care.

The status degradation and "mortification process" of county hospital care was perhaps the most significant hardship. Being classified as a second-class citizen, submitting to uncomfortable tests of financial means, suffering liens on property, and enduring long waits before appointments are implemented are all part of the invidious class categorization of the indigent and denigrate his self-image. As a result, he avoids seeking needed medical care, and this tends to perpetuate his impoverished condition.

In 1967 a grant from the Office of Economic Opportunity (OEO) changed the medical scene in Southern Monterey County by establishing the Rural Health Project in King City. Now disadvantaged persons are able to visit the local private group practice clinic and receive the same level of care as private patients. The transportation problem is solved through a small fleet of vans operated by the project. Communication is fostered through interpreters and health and language aides who were recruited from the recipient population, and supplementary services such as social service referral, family planning, health education, nutrition consultation, and home nursing care are available.

The King City Project is one of 49 OEO-funded Neighborhood Health Centers (NHC), of which 33 are operational and 12 provide limited services.[2] The Public Health Service (PHS) has also provided grants to about two dozen neighborhood health programs and, along with the Children's Bureau (now part of the PHS), shares with OEO in the funding of some centers. Several cities, notably New York, Los Angeles, and Denver, also share in the funding of health centers.

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This paper was presented at a luncheon of the Medical Care Section, American Public Health Association, Honolulu, Hawaii, December 18, 1969.

This paper will highlight some of the accomplishments and problems of the health center movement by focusing on a few of the projects. Descriptions of OEO centers appear elsewhere, so rather than go into program details this discussion will concentrate on how the centers were initiated, on some of the relationships between OEO, the sponsoring agency, and the community, and on some of the major issues and innovations introduced by the centers.

Neighborhood Health Centers

Location and Sponsorship

The 49 NHCs are situated in 37 different cities or rural areas of 23 states. One out of four projects is located in a rural area. There are nine programs in New York (seven in New York City and two upstate), five in California, and four in Pennsylvania. Overall, there are 17 centers in eastern cities, four rural ones in the Appalachian region, six urban and two rural in the midwest, six urban and three rural in the south, three urban and one rural in Colorado and Oklahoma, and four urban and three rural in the far west (including one recently funded in rural Alaska).

Two-thirds of the projects are being conducted by health departments, hospital medical centers, or medical schools (over 30 medical schools are involved—10 as direct sponsors and some two dozen as participants). Two projects are sponsored by prepaid health plans, one by a private group practice, and about a dozen directly by community groups. Medical societies also sponsor or co-sponsor several centers. Community action agencies are the grantees in a majority of projects, but decision-making and control are generally exercised by the operating agency. Control is slowly shifting in a number of projects, however, with the formation of new health corporations involving recipients, community participants, and professionals.

Conditions Prior to NHC

The original "War on Poverty" program did not include health among its priorities. The importance of health was recognized when persons operating job programs found that trainees were refused employment because of disabilities, and when teachers running educational programs found that students could not learn because of physical impairments.[3] It was realized that merely making funds available for medical care (through Title XIX and other programs) would not guarantee that the ghetto or rural poor would actually receive care. Because of the lack of health personnel and facilities in these areas, it was necessary to organize and deliver care directly to the poor from facilities established in their neighborhoods.

The degree and quality of health care received by the poor prior to the establishment of neighborhood health centers has been well documented.[4] Areas where NHCs have developed are typified by a lack of other health facilities (particularly physician and hospital care), poor public transportation, extremely high morbidity, illegitimacy and prematurity, excessive infant and maternal deaths, high rates of unemployment, dilapidated housing, delinquency of all types, malnutrition, and other indicators of extreme poverty.

In Denver, for example, some patients now served by two NHCs formerly had to travel for over an hour to Denver General Hospital on a bus line that charged 60¢ and provided no service at all on weekends and evenings. Patients from Columbia Point, Boston, had to travel 90 minutes by bus and subway—or about as long as it takes to fly from New York to Boston—in order to reach the nearest charity clinic. In East Palo Alto, California, prior to the establishment of the NHC, there were no dentists and only two physicians serving an area of 28,000 persons. In rural Lowndes County, Alabama, three physicians and two dentists served 16,000 persons in an area which spread out over 800 square miles. In the Watts area of Los Angeles, no hospitals and only a few physicians were located among a population of 350,000 people. In the Bronx, where 30 years ago 29 physicians served

30,000 people, the situation had so deteriorated that prior to the Montefiore program only four physicians were available to 35,000 persons. The same situation prevails in the Kenwood area of Chicago: 25 years ago 42 physicians served 26,000 persons, and today just two physicians serve 47,000.

Care to the poor is typified by dismal settings—long waits, hard benches, and crowded waiting rooms; a lengthy series of eligibility screening interviews; insensitive treatment by hurried professionals; and a total lack of continuity. The result is care of the lowest quality—entirely fragmented and presented without regard to language and cultural differences or to human dignity.

A number of political and traditional factors should also be mentioned: the many years of serving the poor from charity facilities; the opposition of the American Medical Association to any attempt to change the delivery of care to the poor; the almost total lack of involvement of medical schools in primary care *outside* the medical center; and the high cost of providing medical and dental services in areas where there is a weak political base. Relevant, too, is the weighing of priorities for funding when the nation is involved in a costly overseas war which draws off a disproportionate amount of available resources. It is against this background that OEO health centers were developed.

NHC Guidelines

Briefly, OEO guidelines[5] call for a "one-door" center providing comprehensive outpatient services from qualified professionals. Two concepts have become an integral part of all programs: 1) training community residents in new jobs as health workers and in roles as agents for community change; and 2) community involvement in planning and conducting the program. Dignified and flexible eligibility standards; the use of OEO funds as the "last dollar" in order to coordinate and utilize existing Federal, state and other support; and the inclusion of reporting and evaluation as part of the program goals are other integral features of the OEO framework.

Tufts Health Centers

The first OEO Center was started in 1965 in Columbia Point, Boston, by Count Gibson and Jack Geiger of the Tufts University School of Medicine. Gibson felt that the university medical school should relate to a defined population by delivering primary care. Geiger, who had been exposed to the health centers operated by Sidney Kark in South Africa,[6] was impressed with the idea of using indigenous nonprofessionals as aides and "health gossips." Gibson and Geiger worked together on the 1964 Medical Committee for Human Rights, Mississippi Summer Project, and there they exchanged ideas on community health centers. In early 1965 they approached OEO with a request for a $30,000 planning grant to develop a health center under the General Community Action Program section of the Economic Opportunity Act of 1964. At first OEO officials were startled by the request; but after considering it they offered to fund a center at Columbia Point, which is a public housing project on a peninsula in Boston Harbor where Gibson had been involved in a home care project.[7] OEO helped Geiger and Gibson develop the proposal, and in June, 1965, Tufts received a grant of $1.1-million to operate a health center at Columbia Point and to plan a second rural health center in a southern state.

The Tufts group met with community residents in their apartments and explained the program at a series of 50 meetings which attracted as many as 20 participants each. From these meetings an ad hoc committee of residents was formed which later evolved into a lay health association of 28 board members.[8] The association serves in an advisory capacity to the Tufts Medical School, which receives the funds and holds the policy and decision-making power.

Mound Bayou Center

For its southern rural health center, the Tufts group selected northern Bolivar County, Mississippi—the nation's third poorest county. Only three physicians served the black population of 40,000 in this large area of rural Mississippi, one of the nine states that had not yet implemented a Title XIX program.[9]

John Hatch[10] of the Tufts staff and Mrs. Pearlie Robinson,[11] a long-time resident of Mound Bayou, described the start of the program at the annual American Public Health Association meeting. Mrs. Robinson stated that when the Tufts team came to her church in Mound Bayou she was suspicious, because white men had appeared at the church before only on the occasion of a servant's death or "to try to sell insurance or to perpetrate some other scheme to get the poor people's money." She was surprised that the team remained and talked about doctors, nurses and health care. Mrs. Robinson was relieved when the Tufts team left and was again surprised when they returned several months later. This time, she said, there were a number of blacks and whites, non-doctors as well as doctors and nurses in the group, and they had come to live there. She said: "No one would have much to do with them at first, but they did a smart thing when they got a minister on their side who had never been involved in a dishonest scheme." Now she and others were willing to listen. They told the Tufts team that they didn't care about a health center; what they needed was food, clean water, sanitation, better houses and jobs.

The Tufts team listened, and rather than "push" the health center they assisted the community in forming a farm cooperative, improving sanitation and housing, and in applying for funds for other community improvement projects. One of the projects is a cannery which is running very smoothly. With these positive results, the community was willing to support a health service, which opened in a church parsonage, using the kitchen for a laboratory. The Tufts Delta Health Center is now a modern health facility and operates with a well-trained professional staff supplemented by indigenous aides. The center serves 14,000 people (90 percent black) in a 400 square mile area.

The center staff has helped the community to apply for a separate grant to bolster two small hospitals sponsored by black fraternal societies. The two hospitals, which cover an area of four counties, were merged administratively under an OEO grant award in 1967. The governing body consists of 18 directors: three each from the two fraternal orders, three from community organizations, six from the poverty population, and three members who need not reside in Mississippi but are elected by the other 15 directors.

Montefiore NHC

Montefiore Hospital and Medical Center in New York City was awarded an OEO grant in 1966 to provide medical care for a 55-square block area of the southeast Bronx crowded with 45,000 people, mostly black and Puerto Rican. Wise, Levin, and Kurahara describe the area as typical of a blighted neighborhood: run-down factory buildings, idle men, empty tenements, garbage on the streets, abandoned cars, and evidence of theft everywhere.[12]

The Montefiore program, like that at the Tufts' centers, was planned by professionals not living in the area. A storefront office was opened in the community, when the grant was awarded, to explain the program to residents. When it became apparent that residents were not being attracted to the office, the staff moved into laundromats and restaurants and held meetings in apartments, but these meetings attracted only four to six people.[13] The problem appeared to be a mixture of skepticism, mistrust and hopelessness on the part of residents long accustomed to neglect, abuse and frustration. The staff learned that the community gave low priority to health compared to other problems, that it resented the second-class service represented by a storefront, and that it generally misunderstood the role of subprofessionals, who, it thought, would

be used in lieu of doctors and nurses rather than as extensions of the health team.

Since only a small number of residents could be reached during the first year, an ad hoc community advisory board was set up temporarily until a formal body could be elected. The few persons who attended meetings became "board members." Eventually it was suggested that meetings be held in three separate parts of the community, and this method tended to increase attendance. Subcommittees on training, medical care, research and board development proved popular, particularly those sessions that set criteria for the selection and discipline of trainees and that decided priorities for registration of patients.

The staff debated the question of how much control to allow the advisory committee. Opinions ranged from "strictly advisory" to "full control of hiring and firing." One year after the project began, a 21-member Community Advisory Board was elected from among 52 delegates who had each collected 25 neighbors' signatures. It was expected that advisory members would report back to their neighbors, but few did.[14]

Training Program

A former "five-and-dime" store was renovated, and physicians, nurses and health workers began serving patients while a larger health building was being prepared. The center launched a program to train community residents as aides. It discovered that the poor were more interested in the training than the health program, and therefore training "assumed a much more important role in the program than originally perceived.[15] Wise reports that the policy of training community residents and giving them employment preference presents problems:

> For every trainee accepted into the training program literally dozens are rejected, each one potentially angry with the agency. Each job available, especially in the paraprofessional area, attracts many applicants; and here, too, the unsuccessful ones are likely to be resentful.[16]

Other problems arise with disciplining and firing employees who are local residents; and because "aide" positions (in contrast to paraprofessional jobs) have low prestige and income, these positions are not particularly attractive to low-income residents.

Employing community residents as aides has advantages in bridging the gap between professionals and neighborhood consumers and in broadening community support of the programs. In addition, it serves as a source for learning about community concerns. However, Wise points out that subprofessionals must be carefully supervised as "the 'half-life' of the subprofessional, during which he still identifies with the consumer, may last less than 24 hours . . . he may begin to talk about . . . 'those people,' and to act in the same way as he had been acted 'upon' when he was on the other side of the establishment's desk."[17] It was found that successfully employed trainees began migrating out of the area and thus lost their identification with the neighborhood.

Additional problems arise during the training period. Although professionals make earnest efforts to insure good training, the supervision is frequently inadequate. Zahn points out that many programs "are short of staff and the volume of the work makes it difficult for the site instructor to devote much time to the trainees. A cycle ensues: the staff shortage means that the trainees cannot be given adequate supervision; the inadequate training results in a shortage of adequately trained personnel."[18]

Launching an NHC in an area with a shortage of personnel and facilities requires a lead-time of at least one year. The Montefiore program began limited service just before the end of its first year.

The Montefiore NHC offers "team care" by a pediatrician, adult physician, two public health nurses, and from four to six family-health workers. Each team is assigned to a 12-room unit, and all mem-

bers of a family go to the same area for each visit. In addition to psychiatric, dental, and other health-care services, the project has developed a program of community health advocacy which includes community development, training, and health education.[19] The staff also conducts a quality audit, on-going data collection, and special research projects.[20]

Rural Health Project

The Rural Health Project in King City, California, which was mentioned earlier, is unique in that it represents the only group of private physicians sponsoring an OEO health center. Similar to the Kaiser-Portland and Bellaire, Ohio, programs, poor patients are provided equal care alongside other patients. In addition, the program reaches out with community health aides, public health nurses, health educators and social workers.

Conceived by Len Hughes Andrus, medical director of a rural-based private group practice, the project was endorsed by California State Poverty Chief Paul O'Rourke. In 1965 I was commissioned by Dr. Andrus and Lee Roberts, the clinic manager, to write a proposal for an OEO center grant to the Monterey County Medical Society for a project to be conducted by the Southern Monterey County Medical Group in King City, California. The grant was approved in 1967.

Southern Monterey County, an agricultural valley surrounded on both sides by mountains, lies 50 miles south of Salinas and has an area population of 15,000. The principal town is King City, with 4,000 people. The size of the population eligible for NHC services fluctuates from 5,500 during the winter to about 8,000 during the growing season when migrant families come to the area.[21] Prior to the establishment of the project, indigents at the southern end of the county had to travel 85 miles for medical care.

One advantage of a grant to an on-going medical group is the speed with which services to the target population are implemented. In the case of King City, within five weeks of notification of the grant award, comprehensive medical services were offered to recipients. What is remarkable about the Rural Health Project is that it was able to provide a full range of services before previously funded programs such as Montefiore and Watts, both among the earlier centers, were able to do so. Supplementary services such as health education, family planning and home nursing were not instituted immediately because personnel first had to be recruited and trained.

Most centers are costly, since usually the building, equipment and staff all have to be developed from the ground up. These projects represent a further feat in that, being established in areas where care has not previously existed, they demand much planning and a good deal of local initiative. At King City, there was no OEO capital investment necessary as the facilities were first rate. Later, as the project developed, facilities became overburdened and the medical group had to expand the clinic. Since it was hard to attract qualified professionals to this rural area, some project positions were difficult to fill (in one instance, the position of training coordinator remained unfilled throughout the center's first two years). Temporary physicians had to be recruited, and outside consultants and professional staff had to increase their workload in order to train the variety of aides recruited from the poverty population.

One disadvantage of a professionally developed program is the lack of recipient participation: The King City project was developed without involvement of the population to be served. The original project committee consisted of the medical director, clinic manager, medical society secretary, medical care consultant, and a medical management specialist. There was no significant community action program in the area until the project staff interested recipients in this activity.

A number of OEO centers have benefited from the involvement of a dominant individual, better described as a strong personality, who has a sense of social re-

sponsibility geared toward changing the medical care scene, and who possesses personal convictions aimed at improving the health of disadvantaged persons. This is true of the King City Project, where Andrus, a physician who grew up in this rural area, has been the driving force behind the program. Without his imagination, energy and willingness to adopt innovations in the delivery of medical care, the Rural Health Project would not have gotten off the ground.

Organizing Consumer Participation

Because 85 percent of the recipient families were Mexican or Mexican-American, a Spanish-speaking community organizer and a Spanish-speaking social worker were engaged at the start of the project, in June, 1967. They went into the fields and migrant labor camps, describing the project and recruiting aides to serve as interpreters and eligibility interviewers. The community organizer formed an ad hoc committee composed of seven project participants, selected on the basis of staff members' recommendations. The committee met in August with the medical director and project coordinator, but it exerted no initiative to call another meeting. The project staff busied itself broadcasting the program, recruiting and training aides, and enrolling eligible patients and transporting them to the clinic. The ad hoc committee was not called together again until December, and the result was that only two members appeared. It was decided to call a public meeting on a Sunday afternoon (with beer and tacos served). About 200 Mexicans and Mexican-Americans turned out, and a large number expressed interest in a consumer's committee. To capitalize on the immediate enthusiasm, a meeting was called for the following night. Twenty-five persons attended. They decided to select a Consumers Advisory Council of 12 representatives from different neighborhoods within the area.

Four meetings of the council were held the following month, during which procedures were adopted, officers were elected, and a delegate to the County Consumers Advisory Council (CAP) was chosen. Largely through the initiative of the project administrator (Stuart Allan), meetings of the council have been held regularly every two weeks, and business is conducted in both English and Spanish. A rule was adopted that any council member missing three meetings would be dropped from the committee, and that any recipient attending three consecutive meetings would become a council member.

Toward the end of the center's second year, the project committee voted to reorganize so that consumers might participate. The medical director, clinic manager and medical society secretary remained on the committee, but the medical care consultant and management specialist resigned and were replaced by a community representative, a County CAP representative, and two Spanish-speaking recipients from the Consumers Council. The CAP chose a professional's wife rather than someone more representative of the poor population to serve on the committee.

The advisory council has maintained fair attendance (eight to 10 members are usually present) and currently consists of nine Spanish-speaking persons and two Anglos. All committee members are either employed or retired agricultural field or shed workers. The council screens all nonprofessional applicants, serves as a grievance board, and reviews and recommends program changes to the project committee. The project staff, with the advice of the council, is currently developing a proposal to change the system of payment from fee for service to capitation. Although the council has exerted authority in reviewing complaints and has suggested program changes, some of which have been adopted, the project committee continues as the policy-making body. There is a realization on the part of the administrator and project director that the project committee should become the operating agency for the grant and, in turn, contract with the medical group to administer the project.[22] This would re-

sult in a further evolvement of the project committee, with the project director becoming an ex officio member, and the committee being expanded to include professional and community members. This change will strengthen the consumer voice all the more.

The role of the consumers has grown slowly but steadily stronger so that the recipients now exert influence in the program. This was illustrated recently when the project committee decided to decrease the target area. The consumers disagreed and managed to get this decision reversed. Consumers who formerly had to go out of the area for medical care are now communicating their needs and desires to professionals who listen. Through this project the two groups are working together to establish a new system of medical care delivery.

East Palo Alto–East Menlo Park NHC

North of the Monterey County Project, another California plan—the East Palo Alto–East Menlo Park NHC—serves disadvantaged blacks. The project differs in many respects from the one just described, but is similar in that it enjoys the presence of a strong personality committed to providing comprehensive care of high quality to poor people. This individual—Paul O'Rourke, the center director—has been successful in encouraging and developing a high degree of consumer participation and control. The result has been that even though the plan was conceived by professionals and developed and sponsored by a public agency—in this case the county Health and Welfare Department—the voice of the consumer has grown so loud that today the Board of Directors of the Center's Community Action Council is clearly dominated by local residents. (Originally the board was composed of five welfare recipients, five community residents who were not recipients, and five professionals. Today the majority of board members are disadvantaged community residents.) Although the Health and Welfare Department still maintains fiscal control and coordinates hospital care, it is likely that within a few years even fiscal control will shift to the council board.

This consumer participation was certainly strengthened by O'Rourke's advocacy, but it came about also as a result of neighborhood residents exerting their demand for a voice in decision-making even before O'Rourke became director. This community action is described below.

Community Power of Negation

The project was designed by Gordon Williams and H. D. Chope, two physicians associated with the Health and Welfare Department, and the original application considered the project to be a function of that department.[23] The proposal specified three project committees, their primary purpose being to evaluate the project from three different points of view: a "professional committee" composed primarily of health and welfare agency personnel; a "Community Action Committee" made up of community leaders and representatives from community action programs; and a "Consumer Committee" made up of recipients elected by enrollees in the project.

The project was presented to the Human Resources Commission, which included representatives of the black community active in formulating community action programs. The local CAP was not included in the formulation of the project and, in fact, was not even consulted before the application was sent to OEO. CAP members were incensed that they had not been consulted. They demanded that OEO return the application for their review and warned that if the project were funded without their approval, the CAP would not support it. The application was returned to the community for its review. This illustrates an important principal: *local residents possess the power of negation but not the power of control.*

The grant application was first modified by describing the project as a collaborative effort within the community, and by recognizing that fiscal and administrative

responsibility could be transferred to a representative advisory group after the demonstration period.[24] Subsequently, with the participation of the CAP and other local residents, additional major changes were effected: The target area was extended to include East Menlo Park; eligibility procedures were assigned to neighborhood aides; all social workers and public health nurses employed by the center were to have their offices at the center; the program for employing nonprofessionals was greatly expanded; and the training of local recipients for new careers as health workers became a central focus of the project.

In addition to the three committees originally designated, a fourth, called the "Steering Committee," was added. The revised proposal specified that this committee would be the governing body, and that it would, "at the close of the demonstration period, reconstitute itself into a governing board."[25] A controversy developed over whether the committee should be a "body" or "board," with the local residents winning out and the Steering Committee being designated as the "governing board."[26] The board was granted full policy-making responsibility, including those that concerned administrative and personnel matters. The project director became directly responsible to the board rather than to the health department, although the latter continued to exert influence in this area.

In several other NHCs the community was also approached *after* the grant had been funded. This resulted in apathy in some cases and resentment in others. What happened in East Palo Alto was perhaps fortunate. The community became involved through its own insistence and initiative. This issue organized the community and has been a positive force in engendering support for the NHC. In this case, the involvement of the community led to a structure which includes active recipient participation, a program more suited to community needs and desires, and increased local support for the center.

Conflict over Regulations

Later in this project, an issue developed which demonstrates the conflict that can arise between the community and the regulations specified in Washington which the funding agency must follow. The problem concerned the type of facility planned as the health center. The original plan to use a renovated building as the clinic was rejected by the board. OEO insisted on renovation because there was no Congressional authorization for capital outlay. However, the community was equally adamant in wanting a new facility built to incorporate community needs and ideas. After six months, OEO finally agreed to allow the community to plan a new building to be financed with FHA support under the Group Practices Facilities Section of the National Housing Act.[27] The architects, Hirschen and Van Der Ryn of Berkeley, incorporated into their design the ideas and suggestions proposed by recipients. The plans call for a patio, small area waiting rooms, an auditorium which can be used for community meetings, an office for the board chairman, a demonstration kitchen for nutrition and homemaking, and a training area. The building will be one of African design and furnishing, and will feature an area for black artists to display their work. It will also house a "health museum" to be used for educational purposes, and a day care center for employees' preschool children. The medical-dental section will include team areas in which physicians (adult, child and Ob-Gyn), nurses, a dentist, a social worker, and three aides will coordinate care for whole families: All members of a family will visit the same area rather than disperse, as is the case in so many medical facilities, the child going to a pediatric section, the mother to an Ob-Gyn wing, the father to another section, etc. Care of each individual will be coordinated with care of the other members of his family. It will be interesting to compare centers that use renovated buildings, planned by professionals and architects, with the East Palo Alto Center, planned

by architects with enthusiastic community participation.

The project has an extensive training program and the board is actively seeking a black director to head the staff, which is composed of about 85 percent black employees.[28]

Open-Door Policy

OEO offers health care to the poor only. O'Rourke comments that it is a serious mistake to exclude the "working poor" who are without resources to pay for their care. He points out that if the center is to become a community facility it must find a way to permit anyone who chooses to use the center without regard to income status. O'Rourke is anxious to get OEO's agreement to experiment with a prepayment package, through a patient cooperative or some other mechanism, which would permit an open-door policy.

Consumer Involvement

The first point that comes to mind in reviewing these centers is the difference in their early histories, despite the many similarities in their initiators. All these projects were initiated by idealistic white physicians and designed primarily for minority persons. Among other centers, a minority (such as the one in Alviso, California) were originated by non-physicians with strong community involvement.[29] On the other hand, regardless of sponsorship, early history, or varying emphases and modes of operation, all NHC programs are essentially similar.

Lack of Consumer Participation in Early Planning

Despite the guidelines of "maximal feasible participation of the poor,"[30] all of the early and most of the later health centers were originally conceived and developed by professionals, with a notable lack of consumer participation. Schorr and English have pointed out that "the fact that the early constituency of the neighborhood health center program consisted, by and large, of the providers and not the consumers of service was later to lead to difficulty."[31] They admit that OEO "did not fully appreciate that the requirement of full participation by those being served after a proposal had been approved could never make up for the fact that the project had been originated and formulated by the professionals alone."[32] This last statement is supported by Sparer, Dines and Smith's preliminary study of consumer participation in 27 NHCs, which showed that only seven of the 27 centers were rated high in the degree of consumer participation; of the other 20, 11 were rated low and nine moderate.[33] In six of the highly rated groups there was a strong personality with consumer orientation, and three of these persons were professionals. It should be noted that the 27 groups studied were generally the older centers, where there had been recognition of the problems and need for progress in consumer participation.

The fact that professionals often wrote project applications without consulting the recipients concerned, or without informing themselves of the specific needs, expectations and past experiences of the residents, partially explains why many consumers resented or mistrusted the program and delayed participating constructively. Conflict itself is not always disruptive. Sometimes it will unify the community. In Watts, Los Angeles, a conflict over policy control between the sponsor (the University of Southern California Medical School) and the community has evolved into a shift of responsibility from the university to the community. Indeed, the community has matured through this controversy, and soon the community council will become the grantee and assume complete control of policy.[34]

It is too simplistic to conclude that projects developed by professionals with little or no consumer involvement are doomed to failure, or that consumer involvement cannot be developed after the project is initiated. East Palo Alto community residents are the effective policy makers in their project, despite its professional origin. The King City and Mound

Bayou projects illustrate the fact that centers initiated by professionals can be successful, but it is not known if initial consumer involvement would have led to a better plan. It would be a gross oversight by well-intentioned professionals to believe that the community can be easily involved *after* the program becomes a reality. On the other hand, there is no assurance that plans with consumer sponsorship or participation will achieve success.

My study of consumer health cooperatives and private physician plans showed that the real power often did not lie with the consumers and that many factors influence consumer participation and the health program which evolves.[35] Formal representation of laymen does not guarantee their effective participation. As a result, some physician plans were more attuned to patient needs than some consumer cooperative plans. However, lay consumers in cooperatives were able to generate more favorable eligibility and enrollment policies, grievance procedures, and extra medical care benefits. Consumer participation provided a general benefit in the form of heightened communication between consumers and staff members around specific improvements in the program.

Value of Consumer Voice

Goldberg, Trowbridge, and Buxbaum review the issue of community involvement and state that "whatever the structure of the emergent health center, it must include community participation as an active and integral element."[36] Davis and Tranquada comment that *logically* it is not necessary to involve the lay community in group decision-making about implementing a community health program; rather, it is enough to involve the community people as advisors.[37] But *strategically*, they say, if success is important, the community should be involved "in a way which provides the local people with autonomy and a sufficiently strong power base to insure major influence, so that they have the opportunity to control their own destiny."[38]

Participation by recipients in Neighborhood Health Centers is already being recognized as valuable. Sieverts, of the Hospital Planning Association of Allegheny County, Pittsburgh, observed the neighborhod health committee of the OEO Center in Pittsburgh and reported that they had a grasp of comprehensive health care equal to that of any hospital board in Allegheny County. He states:

> Many of us who have been dealing with this problem are more and more impressed with the quality of leadership that can come out of the low income neighborhoods, with the depth of understanding of complex health delivery problems that these groups can develop in a very short time.[39]

Sieverts points out that the special needs of the poor must be considered by hospitals planning to serve the neighborhood.[40] He says that this can be done through communication with the poor and by representation—permitting the poor to participate in the decision-making which affects their health services. He suggests that in addition to neighborhood coordinators and advisory committees, hospitals "might even take the revolutionary step of putting some low income or minority people on the governing board of the hospital."[41]

John Hatch sees participation of minority consumers in health institutions in a broader sense. He says that

> . . . the focus for service organizations should be directed toward becoming an ally in the community's legitimate struggle for self-improvement rather than seeking narrow involvement aimed primarily at gaining sanction or support for the continued existence of the institutional structure. Change in the relationship of Americans and the institutions that service their basic needs is going to come. The only unanswered question is how. The how depends to a considerable extent on our ability to de-

velop an honest partnership with those we serve.[42]

Recognition of Consumer Expertise

"To function effectively," state Goldberg, Trowbridge and Buxbaum, "a committee must achieve expertise in both the mechanics of reaching committee decisions and in the gathering of adequate information about health problems. . . . The Committee must acquire a familiarity with ways of providing care. . . . They must gain expertise in dealing with the influential individuals . . . learn to spot natural allies and to form working relationships with these individuals or organizations."[43]

Alberta Parker, of the University of California School of Public Health, conducted a Consumer Health Project among board members of NHC and Model Cities projects aimed at dealing "with some of the difficulties of the consumers through a training program."[44] Through the study it was found that one of the areas of conflict in policy-making is the misunderstanding that exists between lay consumers and professionals. The Consumer Health Project found that: "Community representatives feel that they have valuable skills in community organization and communication which the professional ignores or refuses to recognize."[45] Some representatives believe that to value professional expertise is tantamount to denying *their* expertise as community representatives. The professionals, on the other hand, look on expertise as skills gained through academic study; they often do not comprehend the significance or even existence of consumer expertise in "knowledge of the community."

Concluding Comment

When low income residents sit on community boards their inexperience and appropriately derived mistrust appear to propel them into conflicts with administrators on a wide range of issues not clearly defined in their minds as administrative implementation rather than policy determination. There is a misunderstanding on the part of consumers as to exactly what policy or administrative areas are, and sometimes the professionals attempt to claim decision-making rights in areas which clearly belong to the policy-makers.

Sometimes the consumer role is narrowly interpreted. Falk points out that "influencing hiring in nonprofessional jobs tends to be *the* most important issue to many [health plan boards] but community representatives have *not* attempted to dominate hiring and firing of doctors or other professional or technical personnel."[46]

Another difficulty, and perhaps the greatest, is in communication between the two groups. It is this area which can create conflict, confusion, and mistrust. From her experience in training board members, Parker concludes that in trying to reduce the great gap of understanding between the professional and the consumer, it is equally important to change professional as well as consumer attitudes.[47] Jack Geiger raises this same point but hits at what I think is the crux of the issue. He says it is "painful and stressful for the professional . . . to be involved and challenged; to have his half-conscious needs for gratitude and subservience by his clients go unmet; to accept that clients have relevant skills and that professionals are not the only (or primary) source of care."[48] Geiger adds that the professional does not want "to surrender control."

An effort should be made to train consumer board members in how to identify proper areas of concern and emphasis, and in how to express their wishes. Administrators and professional staff members also need training to identify proper areas of concern and emphasis for them, as well as how to express their wishes in terms that low income consumers can understand and accept.

The American health care system is a middle class system, and as far as the poor are concerned, it needs to be altered if it is to serve them. One problem then, is how can the low income consumer de-

sign these changes and interpret them to the middle class administrators and health practitioners?

In tracing the evolution of a few selected OEO centers, this paper has attempted to compare different styles used in approaching the universal problem of providing professional health care to disadvantaged persons through governmental involvement. It has stressed the need for greater understanding of community needs and the desirability of attracting early and meaningful consumer participation.

In commenting on areas of conflict in the projects, an attempt has been made to point out some of the complex relationships which exist between the professional and the health consumer. Greater understanding and facilitated communication between these groups will likely lead to a more relevant program and fiscal economics. Other beneficial results would be improved care to disadvantaged persons and closer ties between the "helping" agency, the providers of care, and the poor (particularly minority individuals), as well as a modification of the attitudes of each in dealing with the other.

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5 Office of Economic Opportunity. *Guidelines for Comprehensive Neighborhood Health Services Programs.* (February 1967 and revised March 1968)

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22 This change became a reality in July, 1970.

23 Chope, H. D., Williams, G. F., Rubenstein, E., and Jessup, B. *Family Physician Project: Application to Office of Economic Opportunity for Demonstration Project.* (San Mateo County, California, September 30, 1965) p. 5I.

24 Chope, H. D., Williams, G. F., and Rubenstein, E. *East. Palo Alto Neighborhood Health Center: Application to Office of Economic Opportunity for a Demonstration Project.* (San Mateo County, California, March 27, 1967) p. 5K.

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26 *Ibid.*, p. 5Z(7).

27 It should be noted that funding difficulties have resulted in a temporary halt in building plans.

28 Subsequent to the writing of this paper, Paul O'Rourke, M.D. resigned and was replaced by a black director.

29 A few projects were initiated by black physicians, such as Meharry's Neighborhood Health Center.

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34 The community council has now become the grantee for the Watts NHC. There was a great deal of subtle interplay as to some of the reasons why there was a shift from the university-controlled situation to a community-controlled center. Unfortunately, these reasons have not been documented by individuals who participated in the events.

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