III-B

"MEETING HEALTH CARE NEEDS AT THE NEIGHBORHOOD LEVEL IN THE INNER CITY"

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PROVIDING HEALTH CARE FOR THE DISADVANTAGED

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In spite of the noteworthy achievements in the control of some of the major infections and communicable diseases throughout the world, the majority of underprivileged persons in all parts of the world still lack easy access to reliable health services. In a highly industrialized country like the United States, without a National Health Service, the major factor contributing to this deficiency is concentration of trained health personnel in urban communities to the neglect of the rural areas. Urban areas, however, still have pockets of neglect, the minority ghettos, usually in the inner cities.

During the last ten years, resulting chiefly from the minority protests, an attempt was initiated to alleviate this problem. At first sponsored by OEO (Office for Economic Opportunity) and later by the Department of Health, Education and Welfare, residents of the inner-city communities were encouraged to organize themselves into Health Committees and to apply for Federal funds to finance community or neighborhood health centers which provide ambulatory health care. A distinctive feature of this development is that the community health center is owned and controlled by the community through a Board of elected Directors.

One of the first two such community health centers was the Roxbury Comprehensive Community Health Center, established in 1968. It offers comprehensive ambulatory health care including Pediatrics,

Family Medicine, Internal Medicine, Obstetrics and Gynecology and Mental and Social Health. It has its own clinical laboratory, its own Pharmacy and a diagnostic radiological department.

There is now a network of over 400 such community health centers in the U.S.A., most of which belong to a National Association of Community Health Centers, through which program experiences are exchanged and which coordinates the local pressures for adequate funding by Congress.

The first half of this century has been makred by quite noteworthy achievements in the application of knowledge gained in the biological sciences, especially in parasitology and bacteriology to control the causative micro-organisms, parasitic transmitters and insect and animal hosts of disease in man. Very often these achievements were as much the results of applications of scientific knowledge in fields such as sanitary engineering as they were to the efforts of workers in the fields of medicine or public health. These achievements also demonstrate the unity of the sciences in the common objective of helping toward the attainment of the highest achievable states of physical, mental and social well-being by human-beings everywhere.

The successes in malaria control have not only prevented the deaths each year of millions of infants and adults in countries where this disease often accounted for mortality rates of upwards of 50% among children in their first five years of life, but have also protected many more millions of adults from a high morbidity rate which prevented them from making optimal contributions to the economic development of their countries.

A world-wide disease like yaws has been virtually eliminated. Effective means of treatment are also now available for other diseases including tuberculosis, various venereal diseases, the trypanosomal diseases, and even such previously dreaded plagues as leprosy. Smallpox, which once accounted for millions of deaths and scores of millions of cases every year, is now making its last stand before eradication in the remote villages in the mountains of Ethiopia and the deserts of Somalia.

Because of these remarkable successes, it becomes a matter of concern that the basic health services which are necessary to consolidate the gains already described and to prevent the recurrence of epidemics are still not available to the majority of the populations of the nonindustrialized countries of Asia, Africa and Latin America, in which about seventy (70%) percent of the people live in the rural areas, and share the common denominators of illiteracy and poverty.

What is not generally recognized, and what this paper will try to illustrate, is that even in a highly industrialized and very rich country like the United States, there exist concentrations of populations who, mainly because their poverty excludes them from the mainstream of economic and social progress, are almost as disadvantaged as their counterparts in the so-called "developing world", as far as equal access reliable health services is concerned.

In the United States these communities belong to two categories. The first is the "inner city" or ghetto, usually inhabited by one or several minority groups - Afro-American blacks,

Puerto-Ricans and other Latins, and occasionally poor whites who have not been able to acquire the affluence which is the key to leaving the inner city.

The second category is certain areas of rural America away from the large industrial urban agglomerations. The disadvantaged poor in these areas of rural America are migrant workers, Indians in reservations, Chicanos and the white poor of Appalachia and other areas of small scale individual farming.

Although the ratio of members of the many categories of health professions to the general populations is as favorable in the United States as it is in other industrialized countries of the West, economic and other reasons have led to a concentration of health professions in the large cities, which offer opportunities for the practice of their professions under the best physical and professional circumstances, in adequately staffed and equipped institutions, usually associated with university medical centers. Such an urban concentration has resulted in the deprivation of rural areas, so that there are dozens of counties in all parts of the country which do not have a single resident physician.

The groups to which particular attention is drawn in this paper are the inhabitants of inner city ghetto communities, illustrated by Roxbury, a predominantly ghetto community adjacent to the financial heart of the city of Boston, Massachusetts.

The community comprises about 40,000 residents who live in an about about 4 square miles. Racially they are about 60% English speaking Afro-American blacks, the rest being Spanish speaking Puerto-Rican Americans, French-speaking Haitians, Portuguese speaking Cape Verdians, and a remnant of Irish and

Jewish Americans.

At the very edge of the community are three of the leading medical centers of the country in The Boston City Hospitals and its neighbor, The Boston University Medical Center, Tufts University Medical Center and Harvard Medical School and its associated teaching hospitals.

In spite, however, of the proximity of these medical centers, and perhaps because of this proximity, there are less than a half dozen physicians and dentists residing or practicing in the community.

During the civil rights protests of the sixties, and undoubtedly in response to them, the Office of Economic Opportunity of the Federal Government yielded to the demands of a group of citizens of the Columbia Point area for health services located within their community and over which they had some measure of control. Thus the first neighborhood health center was organized. The group obtained professional guidance and assistance from Tufts Medical School and offered primary ambulatory health care to the community.

Soon afterward the Roxbury residents followed the example of their Columbia Point neighbors and organized the Roxbury Comprehensive Community Health Center, which in two leased facilities, one of them in a shopping center and the other in an unused convent, began to offer primary ambulatory health care.

Today, after eight years, the Center operates in a modern building consisting of a four story administrative block, and a two story clinic wing. The health services offered are in Adult

Internal Medicine, Pediatrics, Obstetrics and Gynecology, Nutrition, Dentistry and Eye Care. The center has its own clinical laboratory, pharmacy and diagnostic x-ray department.

In the beginning the OEO, and later the Department of Heatlh, Education and Welfare, provided financial assistance for these services through a contract with Boston University. During the last few years, however, the funds have been provided as a direct grant to the Health Center. The grant for the current year is $2.8 million, which pays the salary of most of the staff. The equipment, both administrative and professional, has been paid for in previous years by direct grant, and the building is now owned by the Center, mortgage free, because of an unprecedented Federal grant received by the community as a token of their success in their undertaking.

Two very important features of this approach to the provision of health services to a previously disadvantaged group are, firstly community control, and secondly, an interdisciplinary comprehensive care approach.

Firstly, community control. Among the deepest resentments felt by the community before the health center was organized was their experience in the outpatient clinics of the nearby medical centers. They often had to wait several hours before the busy staff could get around to inquire what their health problems were, and when they received attention it was, they often complained, impersonal, as if they were "numbers" and not human beings. In their own health center, the Board of Directors elected annually from the community sets the policy and decides on what services

must be provided. A principal concern is a written statement of the rights and responsibilities of members of the health center. All the professionals are employees of the Board of Directors. In the pleasant home-like atmosphere, the encounters between the health professionals and the recipients of health care are personal and preserve the individual dignity of the patient.

Secondly, the emphasis is on comprehensive health care. Treatment of episodic illnesses is only a part of the emphasis which also includes health maintenance. Each professional belongs to one of two teams, concerned with the health of the patient in all its aspects. At team meetings when the health of a given family is being reviewed, the physician, nurse, dentist, psychiatrist and nutritionist members of the team contribute from their disciplines to the development of a treatment and health maintenance plan for the members of that family.

It is my conviction that the development of this community based approach to health care could become the foundation of a comprehensive health care system so desperately needed in the United States. Today, more than four hundred health centers such as the one I have described form a National Association of Community Health Centers. While it is too early to prove that they are able to provide adequate care at minimal cost, there can be no doubt that they have demonstrated that they are effective models of providing health services to the people, for the people and by the people.