PLANNING FOR NEIGHBORHOOD COMPREHENSIVE HEALTH CENTERS

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CHAPTER I

INTRODUCTION

> The reason the medical systems have not reached the poor is because they were never designed to do so. The way the poor think and respond, the way they live and operate, has hardly, if ever, been considered in the scheduling, paperwork, organization and mores of clinics, hospitals and doctors' offices. The life styles of the poor are different; they must be specifically taken into account.[1]
>
> "And the King will answer them, "Truly, I say to you, as you did it to one of the least of these my brethren, you did it to me.'"
>
> Matthew 25:40

There has been a tendency in recent years to claim that America faces a "health crisis." Government, universities, the disadvantaged, and even some members of the medical profession have stressed the necessity for swift and decisive changes in the methods of health care delivery and financing. The term "crisis" has become a catchword applied to many situations and has perhaps become overused to the point that it has little meaning. As applied to health care, however, it would seem that we do face a crisis situation in regard to the poor who, for various reasons, have not received an adequate level of health care. There is a need for specialized health care delivery mechanisms designed to serve these indigent citizens. This thesis focuses on one such mechanism, the neighborhood comprehensive health center, and examines its role in providing the urban poor with adequate health and social services.

Traditionally, the principal obstacle the poor faced in

receiving health care was cost. Until recently, the inability of certain segments of the population to finance health care was considered the major aspect of the health care crisis. It would seem, however, that the crisis stage in regard to financing health care has been passed. This nation is moving toward the enactment of some form of national health insurance, and while the particulars have yet to be determined, the commitment has been made to institute a more equitable and efficient form of financing. Perhaps it can be said that the crisis stage was passed in the mid-1960's with the enactment of the Medicare and Medicaid legislation and that national health insurance is a logical and inevitable extension. At any rate, we are fast approaching the time when no American should have to go without adequate medical care because of an inability to pay.

While the crisis in health care financing may have eased, it seems to have been replaced by a crisis in the delivery of care. Scientific and technological advances and new financing mechanisms are of little consequence unless they are made available to those in need of them. Proposals for delivery systems range from the health maintenance organizations proposed by the Nixon Administration to foundations for medical care operated by local medical societies to a continued reliance of the private fee-for-service physician. There is no consensus as to which method is best, and perhaps this is desirable in a "pluralistic" society with non-uniform communities each having its own problems and opportunities and each requiring individual solutions.

It would seem, however, that this is not precisely wherein the crisis situation exists. Each of the proposals for changes in the

delivery system has its positive and negative aspects, but none is clearly superior to the others. What might function well in one locality or situation might not in another. However, most of the proposals are aimed at the "middle class" most of whom would be able to obtain adequate medical care once some form of national health insurance is enacted. These citizens have the education, the awareness, and the mobility to take advantage of available medical care, whatever its form, if they can find a way to pay for it. The crisis in delivery lies not with them, but with the poor in our inner cities and rural areas. While the problems of the rural poor are just as severe, the scope of this thesis will be limited to health care delivery to low-income and medically indigent inner-city residents.

The Problem

There are three obstacles which have prevented many inner-city residents from obtaining adequate medical care: availability, accessibility, and cost. While cost or methods of financing are now of secondary importance, the obstacles of accessibility and availability remain.

Aside from the largely inadequate services offered by municipal and county health department clinics, the majority of the poor have relied on the outpatient clinics of large public hospitals for medical care or they have gone without. Having spent considerable time and effort in reaching such clinics, often located at some distance from their neighborhoods, these people have had to endure long waits, crowding, and impersonal care from an overburdened staff. When the services of specialists are required, the fragmented and decentralized

nature of such services has caused further difficulties for the immobile poor.

These inconveniences, in addition to such problems as being forced to take an entire day off from work or finding someone to care for the children, have resulted in many of the poor simply not seeking medical care until it becomes absolutely essential. (The poor usually place "health maintenance" low on their list of priorities because of an understandable preoccupation with a day-to-day existence.) Add to these factors their lack of education and awareness about health and their inability to care for themselves once they have received medical attention, and the dimensions of the problem become clear.

In response to the concern about the health of the inner-city poor, there has been an increased interest since the mid-1960's in the neighborhood health center. Several such centers have been developed at various locations as a part of the anti-poverty programs of the Office of Economic Opportunity and more recently by the Department of Health, Education and Welfare. A continuation and refinement of a concept developed around the turn of the century, these centers are now concerned with providing comprehensive health care, a reflection of the increased awareness of the interrelationships between health and social problems.

This new breed of health center has been successful in some respects and less successful in others. While they have generally had a positive influence on their neighborhoods and target populations, it is fair to state that they have not realized their potential. This is understandable because the recent wave of such centers has been largely

experimental. As such, the centers have experienced problems in the early stages of their development which, in several instances, have interfered with their effective operation and hindered their capability to serve their target populations.

Objective

A point has been reached where the experimental stage of health center development should have ended and the evaluation stage begun. The lessons learned from the experiences of the most recent neighborhood comprehensive health centers should be documented so that future centers may be planned with a greater understanding of the complex factors involved. The purpose of this thesis is to formulate recommendations concerning the social and physical considerations involved in the planning of a health center through a case study of the development of the Atlanta Southside Comprehensive Health Center.

The neighborhood comprehensive health center should have two main goals: (1) to provide adequate health care of good quality which is available, accessible, continuous, and non-fragmented to low-income, inner-city residents; and (2) to attack the socioeconomic problems of these low-income citizens by removing inadequate health care as an obstacle to their self-improvement efforts.

The health center model was established with several characteristics designed to achieve these goals: (1) the center is located in the neighborhood it serves for maximum accessibility; (2) there is a wide range of comprehensive health and social services available to attack the specific problems of the residents; (3) there are special mechanisms to provide continuity of care between levels of the health

care system and to prevent the fragmentation of specialized services; (4) employment and job opportunities are made available for neighborhood residents; (5) the community or neighborhood is allowed and encouraged to play a major role in the planning and operation of the center. The Atlanta Southside Comprehensive Health Center is evaluated in this thesis by examining its success in meeting these criteria. In addition, the criteria themselves are evaluated in the final chapter on conclusions and recommendations.

Assumptions

This thesis will proceed on the following assumptions:

1. Despite great strides in medical science and in the financing of health care, there are significant problems of health care delivery to certain segments of the population, particularly low-income and medically indigent inner-city residents.

2. Adequate health care for inner-city residents is often unavailable or inaccessible and not always of the best quality when it can be obtained.

3. Special programs and innovative methods of health care delivery must be developed to serve inner-city residents.

4. Since there are definite interrelationships between the socioeconomic and health problems of the inner-city poor, a neighborhood health center offering comprehensive health and social services can be an effective tool in meeting their needs.

5. Since there are complex social and physical factors involved, adequate preliminary planning must be undertaken to assure that necessary services will be provided efficiently and effectively at the

health center.

6. The neighborhood comprehensive health center should be part of a regional or metropolitan health care delivery system which should include a neighborhood health center and a community or general hospital providing inpatient and specialized services not available at the center.

Methodology

This thesis analyzes certain factors and makes specific recommendations concerning the planning of neighborhood comprehensive health centers. The following research methodology was used:

1. Literature search pertaining to the advantages of providing services on a neighborhood basis.

2. Literature search pertaining to the history and concept of neighborhood comprehensive health centers.

3. A case study of the planning and development of the Atlanta Southside Comprehensive Health Center.

4. Personal interviews with various officials concerning neighborhood comprehensive health centers in general and the Atlanta Southside Comprehensive Health Center in particular.

5. Literature search and personal interviews to determine the health problems of low-income and medically indigent inner-city residents.

Organization

Chapter II discusses the rationale behind the decentralized delivery of services on a neighborhood basis with special emphasis on

health services. The neighborhood health center concept is examined in Chapter III including its origins, development, and revival in the 1960's. Chapter IV presents a model of a neighborhood comprehensive health center including services it is designed to offer and the principal considerations involved in planning the center. A case study of the Atlanta Southside Comprehensive Health Center is discussed in Chapter V in an effort to examine in detail the planning and development process of a specific health center. Chapter VI will present conclusions about the Atlanta center and make more general recommendations concerning comprehensive health centers.

CHAPTER II

THE RATIONALE FOR THE NEIGHBORHOOD DELIVERY OF SERVICES

The push for the decentralization of services on a neighborhood basis is part of a general trend toward a desire for "community control." Residents of many inner-city neighborhoods feel that they have little influence in decisions affecting them. They also feel isolated from the mainstream of city life and consequently believe that they are not receiving their share of services. This is particularly true for health services which are often located outside of their neighborhoods in centralized institutions which deliver medical care in an impersonal manner, unresponsive to the special needs of inner-city residents. This chapter discusses the neighborhood concept in planning and the advantages it offers in the delivery of services, emphasizing its role in the delivery of health care.

Origins of the Neighborhood Theory

The neighborhood theory as applied to city planning was first expressed by Clarence A. Perry in 1929.[2] In Neighborhood and Community Planning, Perry defined his neighborhood unit as a self-sustaining area embracing "all the public facilities and conditions required by the average family for its comfort and proper development within the vicinity of the dwelling."[3] However, he also stressed the value of the concept of neighborhood planning as a means of involving

community residents in the planning process. Certainly the neighborhood could be used to aid physical planning by dividing the city into more manageable statistical areas. Perry's concept, however, stressed the need for the participation of the residents in the planning and development of their neighborhood and the role that such participation could play in fostering a sense of community.

While originally designed with social goals in mind, the concept evolved into one stressing physical planning. Perry defined his neighborhood unit as the service area of an elementary school district including about 160 acres with a population of approximately 5000.[4] The neighborhood would be bounded by, but not intersected by, major thoroughfares. The possibility of restructuring existing neighborhoods was remote, so attention turned to the creation of new communities based on the concept. Several attempts were made at applying the concept, the earliest and most notable example being the residential subdivision of Radburn, New Jersey in the early 1930's. The concept was applied to a degree in the Greenbelt towns developed by the United States Resettlement Administration in the mid-1930's.

There was little further refinement in the neighborhood theory and it was not applied in the suburban development which followed World War II. It was not until a renewed interest in the "new town" concept emerged in the early 1960's that the neighborhood theory was revived with the development of Reston, Virginia and subsequently Columbia, Maryland. Designed as an alternative to the unplanned suburban sprawl of previous years, many of these later new towns incorporated Perry's ideas through their division into a series of

villages or neighborhoods each with its own school and village center containing a small shopping center. It was hoped that such physical planning would provide a sense of neighboring and community spirit that was once a part of small-town life. It has yet to be shown whether this has in fact completely occurred. Perhaps the most complete summary of the neighborhood theory is offered by Mel Scott:

> The theory was that a relatively small area which provided for most of man's daily needs would enable people to know their neighbors, to form enduring friendships, to take an interest in parochial and city-wide affairs, and generally to fulfill themselves as human beings and good citizens. Even though changing economic and social relationships in urban areas have suggested the desirability of reformulating ideas about social interaction and spatial arrangements, the theory and concept still have considerable usefulness.[5]

The most recent change in the neighborhood theory has involved a shift toward re-emphasizing its social aspects. The emphasis is less on physical planning aimed at indirectly influencing citizen involvement in new communities and more on measures which can be employed to directly increase the level of citizen participation in existing neighborhoods. The goal now is to provide meaningful opportunities for residents of these neighborhoods, particularly inner-city neighborhoods, to have a voice in the development of programs affecting them.

Defining the Neighborhood

This thesis deals with the planning of a comprehensive health center in an existing, low-income, inner-city neighborhood. One of the most difficult problems to be faced in this process is the designation or delineation of the neighborhoods to be served, older neighborhoods characterized by mixed land uses as well as by heterogeneous population characteristics and building types. The American Public Health

Association published the following statement on neighborhood definition in 1948:

> The discussion of neighborhood units . . . indicated that the neighborhood size at which all the requirements for neighborhood facilities can be met is based on the following factors: (a) population which can support an elementary school and other neighborhood community facilities; (b) an area which will meet accessibility standards (walking distance to community facilities); (c) an area which will accommodate the necessary dwellings and community facilities in accordance with space requirements; (d) city planning and administrative considerations which may modify theoretical size within the maximum limits. The most important of these are conformity to appropriate physical boundaries and choice of neighborhood density to avoid excessive multiplication of facilities within a small area.[6]

This section discusses the various concepts or definitions of neighborhoods which can be placed in four categories: (1) geographic boundaries, (2) facility service areas, (3) socioeconomic and cultural character of the residents, and (4) consideration of the neighborhood as a political entity.

Neighborhood Defined by Geographic Boundaries

Perhaps the most common or traditional method of delineating a neighborhood is by using natural or man-made boundaries to define it geographically. Man-made boundaries may include railroad lines, heavily traveled streets or expressways, changes in land use which constitute a line of demarcation and changes in the architectural style and condition of the buildings. Natural boundaries are rivers or waterways, restrictive topography such as hills or ravines and poor soil and water conditions such as swamps.

Another type of geographic boundary used to define a neighborhood is the census tract, census block, or enumeration district line. Census tracts or blocks have several advantages: (1) they allow comparability of the housing, demographic, and socioeconomic data for

the same area over a considerably long period of time; (2) most census tracts contain roughly the same population; and (3) census tract lines are often coterminous with political boundaries, major thoroughfares, and other lines which form the geographical boundaries of neighborhoods. The use of census tracts has the following disadvantages: (1) while comparable in population they vary widely in physical area; (2) some areas have not been redrawn for years which may disregard internal changes which might otherwise necessitate the delineation of more than one neighborhood; and (3) since tract and block lines are drawn for statistical relevance, they may disregard topography and other physical features which are important in neighborhood definition.[7]

It is unwise to rely solely on physical boundaries or census lines. A 1960 American Society of Planning Officials Planning Advisory Service report suggested that census lines should be used to supplement neighborhood boundaries determined by the following criteria: (1) follow census tract lines wherever they are not in direct conflict with other major considerations; (2) group two or more tracts where they are included in the same neighborhood; and (3) follow enumeration district lines when following tract lines is inconsistent with neighborhood composition. This will make additional work in statistical analysis, but the capacity for statistical analysis will not be lost.[8]

Neighborhoods Based on Facility Service Areas

Another method for defining the neighborhood is by basing it on the service area of a community facility. Clarence Perry based his ideal neighborhood on the service area of an elementary school. According to the 1960 ASPO Planning Advisory Service report, "Probably

the most common means of delimiting neighborhoods . . . is to draw the boundary lines approximately coincident with the service area of a centrally located elementary school."[9] Other such focal points which may be used to identify a neighborhood are small shopping centers, libraries, and community centers. Often such a physical element will exert an attractive force throughout the neighborhood. Such a method of delimitation is applicable in predominantly black inner-cities because "In areas of strong concentrations of minority groups, institutions catering to or closely associated with the particular needs of the group will become neighborhood focal points."[10]

This method has definite disadvantages. It is too often used to the exclusion of other criteria with neighborhoods based on service areas tending to be "stereotyped and artificial."[11] The method is particularly inappropriate for older, inner-city areas where existing land use patterns are difficult to remold into a neighborhood on the basis of such service areas. It can be of some value when used with other techniques.

Neighborhoods Based on Population Characteristics

An essential factor which must be taken into account in the delineation of neighborhood boundaries is the socioeconomic and cultural characteristics of the residents:

> . . . plotting a neighborhood pattern over an existing layer of established urban improvements often can take on the proportion of trying to bail out a rowboat with a sieve. Fitting even, regular boundaries to an irregular, overlapping, ill-defined grouping of elements comprising total neighborhoods becomes a frustrating task. More than a design problem, the task becomes a social problem, a political problem and an economic problem.[12]

Some of the characteristics most useful in assessing the population are as follows: the number of children in the family, the age of family members, income level, the employment status of the household head, the length of residence in the community, and the existence of a disabling condition.[13] Such information can be obtained from census data or from local welfare agencies. Through an analysis of such data, it may be possible to determine if the differences between two adjacent areas are sufficient to warrant consideration of them as two separate neighborhoods.

Obviously, the primary socioeconomic or cultural characteristic used to define a neighborhood is the racial or ethnic composition of the population. This is not to say that the differing racial or ethnic composition of adjacent areas is necessarily the principal determinant of a neighborhood boundary. Neither does it imply that black and white sub-areas cannot occupy the same neighborhood. However, where there are two areas of markedly different racial composition separated by a thoroughfare or other physical feature, that feature can usually be considered a neighborhood boundary. The ASPO Planning Advisory Service report states that care must be taken in the delineation of neighborhoods if racial discrimination is involved:

> A rule of thumb that might be followed in cases of ethnic groupings as neighborhood considerations might be to ignore them when they are imposed as a discriminatory practice, but to accommodate them within neighborhood boundaries when they are an expression of their occupants' free choice of housing."[14]

However, it would seem that in the process of neighborhood delineation it matters little whether its racial character is the result of discrimination or free choice.

While the use of racial criteria is valuable in neighborhood delineation, it has definite weaknesses. Those weaknesses include: (1) neighborhood boundaries based on social criteria cannot be listed categorically, are hard to define, and no two are alike; (2) changes in race or ethnic groups do not usually constitute a long-term neighborhood boundary, and where such boundaries appear to be stable, there is often a physical boundary contiguous with the social boundary; and (3) social boundaries are not stable enough to be valid neighborhood parameters.[15]

The Neighborhood as a Political Entity

One method of neighborhood delineation which has received increasing attention is the consideration of a neighborhood as a political entity. There has been a growing trend towards the push for the decentralization of municipal administration and power to city neighborhoods where residents feel that they have been neglected and want more control over their neighborhoods. This trend is not limited to a specific ethnic or socioeconomic group but is as common among poor blacks and among upper-income whites. Perhaps the best method for defining the neighborhood in this regard is to evaluate the membership in local neighborhood associations which have formed to represent and advocate the interests of their respective neighborhoods.

One of the chief spokesmen for the consideration of the political movement among neighborhoods has been Milton Kotler who views the neighborhood as a small political settlement which should serve as the basis for decentralized democratic control and self-determination.[16] He states that "The current development of neighborhood corporations

to gain and exercise local control is quite consistent with the historical character of the neighborhoods as political units."[17] Kotler feels that a neighborhood is not a social unit or a service delivery area but a political entity which should regain its traditional role as a fundamental power base. He is less explicit in describing how these neighborhoods should be determined.

An associated technique for defining a neighborhood is the perception of the residents--how the people define their neighborhood and the allegiance that they feel toward it and their neighbors. Suzanne Keller expresses the view that neighborhood residents have a sense of community identity resulting from the characteristics of their neighborhood, its history and traditions, and the level of interpersonal communication.[18] This sense of identity is particularly important to poor inner-city residents whose preference for services and shops located in the neighborhood reflects cultural and ethnic traits as well as the lack of adequate economic resources required to shop outside of the immediate area.[19] In a further reference to the needs of inner-city residents for a strong neighborhood identity, Keller states that "Those immobilized by old age, family responsibilities, ill health, ignorance, or isolation need the neighborhood most, not only for the satisfaction of their tangible wants for goods and services, but also for intangibles such as gossip and information."[20]

The sense of community or neighborhood identity is strong among inner-city blacks. As Carolyn and Melvin Webber point out, poor blacks focus their lives largely in their immediate neighborhoods. Wealthier citizens have a broader "activity space" and a sense of a

larger community; they are freer to move about because of greater mobility and a better understanding of the total urban environment. This phenomenon results in a paradox in that those who have a more spatially limited perspective are concentrated in the largest political jurisdictions: " . . . or, . . . those to whom neighborhood means the most enjoy opportunities for neighborhood self-government the least."[21]

Obviously, there is no simple method for defining a neighborhood or delimiting its boundaries. Many factors must be taken into consideration and the weight attached to each will depend on the individual circumstances.

Decentralization and the Inner-City Poor

As mentioned, there has been a trend recently in the direction of the decentralization of municipal administrative offices and services on a neighborhood scale in response to increased citizen demands, particularly from low-income, largely black, inner-city neighborhoods. Residents of such neighborhoods lack the resources needed to compete in society and the influence of control over distribution mechanisms for these resources.[22] The residents have been frustrated by the service delivery techniques of public and private agencies dealing with health, welfare, and housing. These agencies have attempted to administer their programs and services to the target population with little understanding of the neighborhood. This benevolent or paternalistic attitude should be changed by seeking to involve the residents in the planning and delivery of the services and by tailoring the services to meet their specific needs. Citizen participation is so poor in

current centralized programs because, as Kotler points out, " . . . they are developed on the basis of an abstractly deduced need precluding community involvement in its deduction. The foundation of such a 'deduced' program rests in the theoretical thought of the outside analyst, not in the practical needs of the community."[23]

The trend toward decentralization is an effort to provide more interaction between the providers and recipients of certain services in the inner-city and to give the recipients an opportunity to influence the manner in which those services are delivered. The inner-city poor face special problems in obtaining services, and, "Increasingly, the purpose of decentralization has been related to people in an urban setting and the problems they confront in relating to the city scale, including problems of accessibility, fragmentation, and differing life styles."[24]

The decentralization trend is a result of three areas of previous experience: (1) the settlement house tradition of social services; (2) the traditional functional decentralization of such facilities as fire stations and police precinct stations; and (3) early efforts at administrative decentralization (little city halls, ombudsmen, etc.) designed to promote greater municipal efficiency.[25] That is, there are four reasons why decentralization of facilities has occurred in the past:

(1) to promote administrative efficiency by eliminating congestion at one facility and putting the facility closer to employees;
(2) to provide accessibility by providing a more approachable small center;
(3) to foster responsiveness and increased interplay by making the citizen more informed and institutions more responsive, and

(4) to provide an innovative approach.[26]

Most such decentralization efforts have been largely experimental. However, with the coming of the civil rights movement, the "maximum feasible participation" requirements of the Community Action Programs of the 1960's and the civil unrest in the cities, decentralization of facilities and services has become a necessity. Rather than constituting a physical planning technique to foster greater administrative efficiency, decentralization is now an aspect of social planning designed to more directly affect the lives of the poor.

The Decentralization of Health Services

A major aspect of the trend toward decentralization is the increased interest in neighborhood health centers as a means of providing health services to the urban poor. The poor traditionally have not received adequate health care because of an inability to pay, inaccessibility of the services, and a lack of understanding of the health care system. Medicare and Medicaid and the impending national health insurance programs will remove inability to pay as an obstacle to receiving adequate health care. However, the poor must still be served through programs and facilities designed to meet their special needs.

Medicine has traditionally been designed to serve the individual. The "country doctor" image evolved from the close personal relationship between physician and patient. Even the poor were able to receive care from a private physician because he had enough income from his other patients to make treatment of the poor feasible. When the more affluent citizens left the city neighborhoods, however, the

private physicians were no longer able to provide care to the flood of poor who replaced them because they were not left with enough patients who could pay the cost of the service. Consequently, the private physicians have left the central city, and a gap in health care for the residents has resulted. The poor are therefore forced to rely on hospital outpatient clinics for ambulatory care. The services offered by public health clinics, when available, are limited to traditional ones such as venereal disease and tuberculosis detection and control.

In addition, there has been a definite trend toward the concentration of health services in large hospitals. Many private physicians who left inner-city neighborhoods relocated in office complexes adjacent to the hospitals. There has also been a tremendous growth in medical technology which has caused the development of many specialists who tend to cluster in hospital complexes. Such a concentration of services, of course, provides economies of scale and facilitates communication among physicians.

As the cities have grown and the poor have migrated into the inner-city, many of these centralized hospitals have become physically and psychologically inaccessible to the poor. Obviously, there are problems in the poor reaching such hospitals for ambulatory care, problems which the middle and upper-income citizens (because of their education, mobility, and access to private physicians) do not face. As Robert Morris states, this is an element of health planning which is "the contradiction between our personal mobility to disperse throughout a metropolitan region and our institutional tendency to

centralize care for those who are less mobile."[27] Morris also points out that the inner-cities are dominated by four groups which have special needs: the young and old, the disabled, the poor, and the mentally ill or retarded. He asserts that these groups constitute a "new kind of minority" and that "The significant fact is that these groups lack the mobility which the trends in our society seem to require."[28]

Even if mobility problems can be overcome, however, and they are able to reach a hospital, the poor are often faced with other obstacles. For example, as Paul Goodman states, "hospitals that are very large because of technical advances may come to be run for administrative convenience even to the disadvantage of patients."[29] The large public hospitals have also become increasingly impersonal as a result of the inability or unwillingness of the staff to communicate and deal effectively with low-income families.[30]

These factors tend to discourage the poor from seeking health care. The poor tend to place health low on their list of priorities because of their concern with day-to-day survival. They are generally unable to initiate the search for adequate sources of health care because of a lack of education and bewilderment at the thought of dealing with the bureaucracy of an institution like a hospital. Consequently, health education and health care services must be provided on a more personal and individual basis, a quality " . . . lacking in the current system where agencies rendering care have excessive case loads and consequently have become increasingly remote and impersonal."[31] There must be more emphasis on personal, ambulatory services

offering preventive care designed to detect and treat illness before it reaches a crisis stage. The hospital outpatient clinic is generally unable to provide such care effectively, and its dominant role in health care provision is being challenged.

While there is a definite need for decentralized and more personal health care services for the poor, however, there is also a necessity for maintaining a significant degree of centralization in large hospitals. Centralization is necessary to counterbalance the complex and uncoordinated health care system. As Jack Geiger and Roger Cohen point out, the greatest challenge may be to develop a mechanism "for centralized coordination and resources, and decentralized operation and control. A framework, both structural and fiscal, which meets system needs, as well as those of the consumers of health care is essential to their development."[32]

There seems to be emerging in many cities a trend toward two levels of health care to provide the necessary decentralization while preserving adequate centralization. The hospital is on one level and remains the major inpatient facility, the dominant source of specialized care and the center of administrative, organizational, and communications talent. On the lower or second level is the neighborhood health center which offers comprehensive health services on a decentralized basis accessible to the poor and responsive to their needs. The neighborhood health center is replacing the hospital as the major source of ambulatory care in urban areas. Hospitals may be involved in developing such centers, but "The shift away from their historical function as the primary institution is significant, and, in part, is

reflected by the new community orientation found in many urban centers."[33] One of the organizers of the Columbia Point Health Center in Boston, Count Gibson, had the following assessment:

> . . . I believe that primary health care must be optimally rendered in a primary location. The difference between the health center and the hospital is not simply that the hospital is more complex and must serve many functions other than meeting the needs of the immediate community that surrounds it. There is actually a sociologic difference in organization between the two institutions, rendering it much more feasible for the health center to relate in a meaningful way to the community in which it is located.[34]

This chapter has discussed the neighborhood theory and the trend toward the decentralization of services and facilities on a neighborhood scale. Health services were emphasized and the neighborhood health center offered as a possible solution to the problems of health care delivery to the urban poor. The next chapter will discuss the origins and development of the health center concept.

CHAPTER III

THE CONCEPT OF NEIGHBORHOOD COMPREHENSIVE HEALTH CENTERS

If the neighborhood concept can be successfully applied, it will be most useful in the delivery of health services. This claim is based on past experience, for health services were being provided on a neighborhood scale at the turn of the century. The services were not comparable to those of a modern comprehensive health center, but they demonstrated the feasibility of service delivery on a decentralized basis and probably provided the impetus for later development of the neighborhood theory. This chapter discusses these early health centers and traces the growth, development, and revival of the neighborhood health center concept.

History of the Concept

The health centers developed during the past decade can certainly be considered revolutionary because of the scope of health and social services they offer. These centers, however, merely reflect the growth and development of a concept nearly a century old.

Early History: The Settlement House

The early movement for the delivery of health services on a neighborhood basis was in direct response to the tremendous influx of millions of European immigrants which occurred during the late nineteenth and early twentieth centuries. The vast majority of these

immigrants settled in urban areas, particularly New York City, Chicago, and Boston. Their poverty, lack of education, and bewilderment with their new surroundings made their adjustment to city life difficult. The story of their crowded and oppressive ghettoes has been well documented. The unhealthy living conditions in their tenements eventually led such men as Jacob Riis and Benjamin Marsh to push for major housing reforms. In addition, the majority of the immigrants were unskilled and had to perform heavy manual labor for long hours and little pay in unhealthy conditions.

In response to the plight of the immigrants and in an effort to help them to adjust to their new homes, the settlement house was introduced into the ghetto. Originally designed as a kind of central meeting place and information center for a neighborhood, the settlement house became the principal source of help for the immigrant in need. In this manner, settlement house workers learned of the health problems of their residents.

The public health movement had previously focused on sanitation problems such as garbage collection, inadequate sewers, and contamination of water supplies. The settlement houses shifted the focus to emphasize personal health matters. One of the first efforts at dealing with the health problems occurred at Jane Addams' Hull House in Chicago. In 1893, four years after it opened, the settlement house organized a public dispensary staffed by one physician in residence, another who lived nearby, and a nurse. Also in 1893, Lillian Wald opened a Nurses Settlement in New York City in an effort to offer public health nursing services to the immigrants.[35]

Other settlement houses followed the lead in instituting health services. Initially there was concern about the impact of poor housing and working conditions on health, but substantial progress in these areas developed later following social and political reforms. However, the work of Pasteur and Koch during this period led to an understanding of the causes and prevention of communicable diseases and enabled the settlement houses to attack such problems as tuberculosis and venereal disease with some effectiveness.[36]

Another important aspect of the health care services offered by settlement houses was in the area of infant care. The infant mortality rate in the ghettoes was high, and the understandable concern with the nutritional problems of the infants led to the creation of infant welfare stations and milk stations. Since the immigrants faced problems in obtaining fresh milk, the settlement houses in many areas established programs to provide them with uncontaminated supplies. Beyond the nutritional problems, however, there developed a concern with the overall health status of the babies. Consequently, in some cities, such as Cleveland, the receipt of milk at these stations was contingent upon the examination of the infant by a physician.[37]

In the area of infant care and other health problems, the emphasis shifted to the education of the immigrants about personal health habits. In reference to educational programs on infant care, one observed stated that their " . . . prime task, as in tuberculosis, (is) to carry sanitary and hygienic knowledge to the individual home."[38] The services offered by the settlement

> . . . were mostly preventive and educational, although some settlements maintained diagnostic treatment clinics. Exhibits

> and lectures were presented on various subjects, such as the protection and handling of food in markets and in homes, baby clinic service, proper clothing and bedding for children.[39]

The Formative Period: 1910-1920

As a result of the lead taken by the settlement houses, the turn of the century saw the proliferation of numerous public and private health and welfare agencies. These agencies attempted to deal with the problems of the immigrants, but because of the special interests of the agencies and the lack of any coordination, the programs overlapped and were improperly administered. One Boston health official had the following assessment:

> Gaps in the programs, duplication and consequent waste, frequent inefficiencies and misunderstandings, could not help but lead to the conclusion that there was a great need for better coordination and correlation, more efficient organization, and more harmonious understanding between those agencies concerned with the public health and with the amelioration of human suffering.[40]

In response to the need for more coordination, municipal and county health departments and welfare agencies were formed. While these agencies improved the efficiency of program administration, they moved the base of delivery from the neighborhood into centralized offices. The personal quality of the settlement house was replaced by the impersonal bureaucracy of a centralized agency. As a result, " . . . the fault of public health administration in large cities particularly was due to the fact that it was too far removed from the people it attempted to serve."[41]

The period 1910-1915 saw an increased emphasis on relating the services to a definite population or district. This resulted in a movement toward the designation of health districts and health centers serving specified neighborhoods.

New York City. One of the earliest examples was in New York City where the City Health Commissioner established an experimental district center in a deteriorating Jewish neighborhood of 25,000 in Manhattan. Its staff included a part-time health officer in charge of local administration, a part-time medical inspector responsible for the inspection of preschool and school children as well as milk stations, three nurses, one nurse assistant, a food inspector, and a sanitary inspector. The experiment was so successful that it was extended to four other districts in 1916 and a Division of Health Districts was formed in the Health Department: "The basic principles underlying district work were coordination of health department functions, local administration in terms of local needs, and establishment of community spirit."[42]

Boston. In 1916, Charles Wilinsky, Boston's Deputy Health Commissioner, opened a "health unit" in West End designed " . . . to provide a local center from which agencies engaged in health and welfare work could serve a geographically defined population." Eventually, Boston had eight centers serving a population of 50,000 each.[43]

Cincinnati. Wilbur Phillips opened a health center in a neighborhood of 15,000. Health services included antepartum care, well-child care for infants and preschool children, anti-tuberculosis work, dental exams for school children, nursing service, and periodic examination of adults. The significance of the program, however, lies in its "Social Unit" concept: the neighborhood was divided into blocks each of which elected a council; each council selected a representative who was to serve on the Citizens Council of the unit, help in policy

formation, and provide personal counseling for each family in his block. Most health and welfare agencies supported the concept, but the opposition of the municipal administration and the medical society plus a loss of funds ended the demonstration by 1920. (Phillips later tried it with some success in Milwaukee.) The significance of the "Cincinnati Social Unit" was that it was "an experiment in applied democracy with health as the focal point" and was a precursor of the modern health center movement.[44]

Los Angeles. In 1919, J. L. Pomeroy, the county health officer for Los Angeles established health districts and associated health centers. The centers included physicians, nurses, and social workers who provided preventive and curative services on an ambulatory basis. The services were available to the poor whose eligibility was established by a means test, but the program was transferred to the welfare department when complaints arose that many ineligible people were using the center.[45]

These examples of neighborhood health centers were representative samples of a national trend. The trend was noted by one observer who remarked in 1919 that "The most striking and typical development of the public health movement of the present day is the health center."[46]

Further Development of the Concept: The 1920's

The growth in the neighborhood health center movement was noted by a Red Cross survey of the centers as of January 1, 1920. (The American Red Cross had joined the movement by encouraging local chapters to establish health centers.) The results of the survey

revealed that there were seventy-two centers in forty-nine communities. Seven cities had more than one center and thirty-three were proposed or planned in twenty-eight other communities. Of those existing and proposed, thirty-three were administered by public authorities, twenty-seven were privately controlled, sixteen were under combined public-private control, and nineteen were operated with Red Cross involvement.[47]

The Red Cross survey also reflected a variation in the work and aims of the centers. In forty communities with operating health centers, thirty-seven contained clinics; thirty-four had visiting nurse programs; twenty-nine did child welfare work; twenty-seven had anti-TB programs; twenty-two had VD clinics; fourteen had dental clinics; eleven had eye, ear, nose, and throat programs; ten had labs; and nine had milk stations.[48]

Health centers were obviously in fashion and were usurping, often replacing, the functions of the settlement houses. Although widely accepted, some of the centers were criticized for being impersonal with too great an emphasis on the services provided and not enough on social considerations. Concern about this aspect of the centers led Robert Woods to state in 1923 that " . . . all the values of acquaintance and influence which the settlement has in its various organizations must continue to be of indispensable importance to any sort of comprehensive local health campaign."[49]

Even the American Medical Association recognized the importance of some form of the centers in the delivery of health care to the poor. In a 1927 report, the AMA's Committee on the Costs of Medical Care

recommended " . . . the development of suitable hospitals into comprehensive community medical centers, with branches and medical centers where needed, in which the medical professions and the public participate in the provision of, and the payment for, all health and medical care."[50] That such a statement was issued by the conservative AMA provides evidence of the attention that the health center concept was receiving.

Perhaps the best definition of the neighborhood health center as it had developed by this point was offered by Michael Davis:

> Observation of a large number of health centers leads to an indication of two factors which all those studied appeared to present: first, the selection of a definite district, or of a population unit, with the aim of serving all therein who need the services offered; second, coordination of services within this area, embracing both the facilities furnished by the health center itself and those provided by other agencies. A definition might therefore be stated as follows: a health center is an organization which provides, promotes and coordinates needed medical services and related social services for a specified district.[51]

The Movement Declines

By 1930, the growth and development of neighborhood health centers had peaked. The concept had become established and had been successfully applied. A 1930 report of a subcommittee on health centers of the White House Conference on Child Health and Protection released data on more than 1511 major and minor health centers. The report stated that 80 percent of the centers had been established since 1910. Statistics released in the report also reflected the diverse sponsorship of the centers: 725 were privately operated, 729 were under county or municipal health departments' sponsorship, and the remainder were run by the Red Cross, hospitals, TB associations, and social case-work agencies. In half of the centers,

principal support was from public funds.[52]

By the mid-1920's, however, the movement had already begun to slow and by 1930 it rapidly declined. The Depression of the early 1930's was a primary factor for their decline, but there were many other reasons.[53]

Loss of Clientele. Immigrants were the original clientele of the centers and remained so through the 1920's. As they were assimilated into American society, however, these immigrants and their children achieved an upward mobility and moved up on the socioeconomic ladder. They moved away from the ghetto and dispersed. Even many of those who remained were able to afford private health care. Consequently, the clientele that the centers were designed to serve simply dried up.

Limited Services. The services offered at most of the health centers were not complete. In 1921, Michael Davis recognized this weakness and the need for a combination of preventive and curative services " . . . so that the service which the people seek of their own initiative can be supplemented by the service which we believe the larger interests of all require."[54] In addition, the therapeutic services available were limited. Private physicians began to provide immunizations and antepartum and well-child care. When antibiotics became available, physicians also treated tuberculosis and venereal disease. This trend was slowed by the Depression but resumed when the national economy improved in the late 1930's.

Shift in the Role of Local Welfare Agencies. As the Federal government began to assume more welfare responsibilities during the

Depression, the role of local welfare agencies changed. Part of the rationale for the health center was to serve as a coordinator for the various public and private agencies. But with increased Federal activity in the provision of welfare services, these local agencies shifted from an emphasis on the community to a concern for the individual and a preoccupation with case work. There was a corresponding withdrawal of these social agencies from health centers into fewer locations where they could centralize their therapeutic services.

Other Reasons. Some other causes for the decline of the health center movement are as follows:

1. Use of the health services offered by the centers declined as health insurance programs developed as a result of labor-management negotiations.
2. The goal of community involvement in the health centers was not realized.
3. There was considerable opposition to the concept from professional medical organizations.
4. Many of the centers were plagued by administrative infighting.

Many health centers closed and others reduced the scope of their services. By 1940, the health center movement had come to a halt and World War II precluded any revival. In fact, there would be no significant change or growth for another twenty-five years. However, the concept had been developed and successfully applied. It could be called upon again when the need arose.

Revival of the Concept

The health center movement grew in response to the plight of

the ethnic immigrants in the early 1900's. When this target population had dispersed or was able to afford private medical care, the chief justification for the centers disappeared. It was not until a new wave of "immigrants," mostly blacks and poor whites, swarmed from the South and other areas into the inner cities and formed their own ghettoes that the special services of the neighborhood health center were called upon once again. Their revival, however, was slow in coming.

The Role of the Office of Economic Opportunity: The 1960's

The development of a new generation of slum tenants in the 1940's and the resulting living conditions prompted government action at the Federal level. The response was typified, however, by the Housing Acts of 1949 and 1954 and the resulting urban renewal program which aimed at removing substandard housing and relocating the tenants in new public housing in the hopes that the change in the physical environment might somehow solve the social and health problems. Just as strong a motivation, at least on the part of some local officials, was a desire to improve the physical appearance of their cities through redevelopment and "Negro removal."

There was little shift in the emphasis of Federal programs until the War On Poverty programs were instituted during the Johnson Administration in the mid-1960's. It was at this point that a genuine interest developed in directly attacking the social problems of the poor. Of the greatest significance was the creation of the Office of Economic Opportunity in 1964.

The OEO instituted numerous programs aimed at alleviating the social ills of the poor and created the Community Action Program to involve individual localities in the implementation of the programs. However, one area in which the OEO guidelines were lacking was health. The administrators apparently felt that the health field was too complex and health care programs would be too expensive.[55]

Columbia Point Health Center. Like other cities eager for Federal funds, Boston joined in the Community Action Program. Almost immediately a group known as the Roxbury Health Committee (which had been functioning for a decade) sought funds to establish a neighborhood health facility to serve low-income citizens. Upon hearing that OEO was not funding health programs, a group of Boston physicians protested by asserting that medical problems are inextricably connected with poverty. These physicians also stated that neither the traditional health care delivery system nor the new Medicare and Medicaid programs were meeting the needs of the poor.[56]

OEO responded by agreeing that health was an important area which should be attacked. Criteria were formulated in early 1965 regarding the creation of neighborhood health centers which emphasized preventive medicine, personal care provided by health teams, and particularly consumer participation possibly leading to community control of the center.[57]

In June, 1965, the Tufts University School of Medicine was the recipient of a $1.1 million OEO "research and development" grant for the development of a neighborhood health center in the Columbia Point housing project in Boston. This project was selected because the

residents had previously been forced to travel ninety minutes by bus and subway to reach the nearest charity clinic. The Tufts group organizing the center held a series of approximately fifty meetings with the residents to involve them in the planning. An ad hoc committee of residents was formed and this committee evolved into a twenty-eight-member lay health association which advises the Tufts Medical School in policy decisions relating to the center.[58] The neighborhood orientation was reflected in the following statement by one of the organizers of the Columbia Point center: " . . . the neighborhood health center stands in the middle of its community and is affected by the same forces. The rats and mice which have long plagued the Columbia Point Housing Development recently invaded our health center."[59]

The response to the OEO funding of neighborhood health center projects resulted in the awarding of $10 million in research and demonstration grants by June, 1966.[60] In addition to Columbia Point, other notable examples of this new generation of health centers were Montefiore in New York City, the Mile Square Center in Chicago, and the East and West Side Health Centers in Denver.

Montefiore Health Center. The Montefiore Health and Medical Center in New York City was awarded an OEO grant for a demonstration health center project in 1966. The target area covered fifty-five square blocks in the southeast Bronx and contained 45,000 people who were mostly blacks and Puerto Ricans. The entire area was being served by a total of four physicians. Like Columbia Point, the project was designed by professionals with no close connections in the

area. A storefront center was opened initially while a larger building was renovated, but when it failed to attract area residents, the staff decided to move out into laundromats, restaurants, and apartments in an effort to communicate with the residents and to form a clientele. Through these encounters the staff learned that the residents gave health care a low priority. Furthermore, the residents viewed the storefront center as offering second-rate services and the hiring of neighborhood residents as paraprofessionals as a substitute for physicians.

Only a small number of residents were reached the first year. An ad hoc community advisory board was established until a formal body could be elected. The few who came to the meetings became board members. Meetings were then held regularly in three different locations and attendance improved. Subcommittees on training, medical care, and research and evaluation were popular with the residents. They were particularly interested in the meetings which set criteria for selection of trainees and set the priorities for patient registration.

The staff debated about the level of community control that was to be allowed. A year after the project began, a twenty-one-member Community Advisory Board was elected. It was anticipated that the board members would report back to their neighbors, but few did. The organizers of the center discovered that the residents were more interested in the job training and employment possibilities of the program than in the improvement of the health of the community. The problems of acceptance by the residents and the lack of understanding

about the health center's goals led one organizer to conclude that launching a center in such a neighborhood requires a leadtime of one year to adequately assess the area and to inform the residents about the project.[61]

Denver Health Centers. The Eastside Neighborhood Health Center was funded in August, 1965, and opened in March, 1966. The Curtis Park-Arapahoe neighborhood contained 40,000 with 31 percent of the families having an annual income of under $3000. The predominantly black and Mexican-American population had higher infant mortality and overall death rates than the city of Denver as a whole but lacked the services of a private physician. The poor were treated at Denver General Hospital (called a "butcher shop" by some) or in charity clinics. Denver General was inconvenient because it required an hour bus ride with a 60 cent fare and no service on evenings and weekends. Denver General is typical of large public hospitals with its long waits, crowding, and fragmented and non-continuous care.[62]

The Denver Department of Health and Hospitals sought the OEO grant to establish the health center to offer the residents an alternative to Denver General and the inadequate charity clinic services. The residents responded and seventeen weeks after opening, the center had seen nearly 7000 patients or 33 percent of those eligible. More surprising is the fact that 21 percent of these patients had never been treated at Denver General. It is unknown how many were new residents, but it is clear that the center was providing treatment to persons who had not been receiving any.[63]

The center offers a full range of services in accordance with

the comprehensive care model. As has been the case with most other health center projects, there has been disagreement among the professionals and the community over policy-making powers.[64] The center was such a success, however, that three months after it opened, the Denver Department of Health and Hospitals proposed another center on the west side which opened in April, 1968, serving a neighborhood of 25,000.[65]

Mile Square Health Center. The Mile Square Health Center opened on Chicago's South Side in February, 1967. The center was sponsored by the Section of Community Medicine of Presbyterian-St. Luke's Hospital and serves an area covering one square mile and a population of 25,000.[66] Community involvement has been important from the start with representatives of the Mile Square Federation, a community organization, approaching Presbyterian-St. Luke's initially to push for the development of a health center. The Health and Sanitation Committee of the Mile Square Federation served as the nucleus of the advisory board. The board helped write the grant proposal as well as to select the site and recruit the neighborhood residents for positions at the center. The policy-making decisions are made jointly by the administration and by the advisory board.[67]

Further Expansion of the Program. The initial response to the OEO funding for the health centers prompted Senator Edward Kennedy to push for an appropriations increase. In September, 1966, he secured amendments to the Economic Opportunity Act of 1964 (Section 211-2) which added $50 million for the funding of fifty health centers. Further amendments in 1967 continued the program with minor changes

under Section 222(a)(4)(A).

The concept of the scope of such health centers was also being further refined: "By that time (1966), an OEO concept was emerging for a 'one-door' facility with all ambulatory health services available, high-quality professional staff, close coordination with other community resources, and intensive participation by the population served."[68] A prime example is the Atlanta Southside Comprehensive Health Center which was planned in early 1967 and which will be examined in detail in Chapter V.

A Shift in Administration to HEW: The 1970's

The impetus provided by the Office of Economic Opportunity and its Office of Health Affairs caused a rapid expansion in the number of neighborhood health centers and a refinement in the scope of the services they offered. Between 1965 and 1971, about 100 neighborhood health centers and other comprehensive health service projects were started with OEO grant assistance.[69] (Other legislation providing health programs for inner-city poor were the Comprehensive Health Services for Children and Youth--Title V, Section 205 of the Social Security Amendments of 1965; and Health Programs of Model Cities--Title I, Demonstration Cities and Metropolitan Development Act of 1968.)

There has been a shift in program administration responsibilities, however. The Department of Health, Education and Welfare has assumed control of most of the programs dealing with comprehensive health care and health centers. (This transfer of authority is now complete with the dismanteling of the Office of Economic

Opportunity by the Nixon Administration.) This shift was initiated by Section 314(e) of the Comprehensive Health Planning and Public Health Services Amendments of 1966 which authorized grants for some comprehensive health projects. (By 1971, HEW had funded about fifty such projects.)[70] Presently, the health centers are funded through the Health Services and Mental Health Administration of HEW.

This chapter examined the history and development of the concept of neighborhood health centers. These centers have reestablished themselves as important institutional forms which can provide health and related services to inner-city residents in the specialized manner required. The following chapter will examine in detail the type and scope of services offered by a modern comprehensive health center.

CHAPTER IV

PLANNING THE NEIGHBORHOOD COMPREHENSIVE HEALTH CENTER

As mentioned in Chapter III, the neighborhood health center concept is not a recent development. It began at the turn of the century, matured through the 1920's, and finally entered a period of stagnation from which it has only recently emerged. This new wave of centers, however, is different from its predecessors. The present health center is designed to attack not only health problems of the poor but also the related socioeconomic problems: the health center should have as its goal the elimination of health problems as an obstacle to the self-improvement efforts of the inner-city poor. The comprehensive services offered are designed to allow the center to serve not only as a health care delivery mechanism, but also as an instrument of social change tailored to the specific needs of low-income, inner-city residents. The purpose of this chapter is to discuss the planning of a modern health center by examining the goals it is designed to achieve, the comprehensive services it offers, and its relationship with the neighborhood and community it serves.

Model of a Neighborhood Comprehensive Health Center

The neighborhood comprehensive health center is designed to overcome the obstacles of unavailability, inaccessibility, discontinuity, and fragmentation which preclude many poor inner-city residents

from receiving adequate health care. The center is also designed to attack the socioeconomic problems of the poor which are interrelated with their health problems. There are several characteristics of the present-day center which are designed to achieve these goals:

1. The center is located in the neighborhood it serves for maximum accessibility.
2. There is a wide range of comprehensive health and social services available to attack the specific problems of the residents.
3. There are special mechanisms to provide continuity of care between levels of the health care system and to prevent the fragmentation of specialized services.
4. Employment and job training opportunities are made available for neighborhood residents.
5. The community or neighborhood is allowed and encouraged to play a major role in the planning and operation of the center.

Perhaps the best definition of a neighborhood comprehensive health center was offered by Dr. Joyce Lashof, Project Directof of the Mile Square Neighborhood Health Center in Chicago:

> . . . an institution organized to deliver comprehensive medical care to residents of a defined geographic area. The health center should be located within the community it serves, and should become an integral part of that community. The community must be involved through its representatives in the planning and ongoing evaluation and direction of the center. The center should contain within one physical location a full range of ambulatory care services including preventive services, acute illness and chronic illness care, mental health and dental services. It should include laboratory, X-ray and pharmacy facilities. In addition, this center should be the focus from which outreach services are extended into the community providing health education, family health counseling and home nursing care. It is most

> important that the neighborhood center have a strong affiliation with a hospital which is prepared to provide specialty referral services and inpatient care.[71]

Accessible Neighborhood Location

The advantages of the delivery of health services on a neighborhood basis were discussed in Chapter II. To summarize, however, there are trends which have increased the necessity of decentralized health services: the abandonment of the low-income urban areas by private physicians and the ascendancy of the hospital as the primary source of health care.

As the upper-income residents have fled the central city neighborhoods, they have been followed by private physicians. This is understandable in light of the fact that treatment of the poor is simply not economically attractive:

> . . . with the concentration of the indigent into large population groups, the medical profession has been unable to fulfill the time honored precedent of providing free services for those unable to pay. In fact, even the small number taking care of them through varied facilities are of necessity reimbursed for their services. This population undeniably feels strikingly the manpower shortage.[72]

It was hoped that the Medicare and Medicaid legislation which enabled many of the poor to finance health care would induce private physicians to return to the inner city. To date, however, no such in-migration has occurred.[73]

The second factor is the increasing importance of the hospital as the primary source of health services. The rapid advancement in medical technology in recent years and the associated specialization of physicians have resulted in the clustering of physicians and health care services into large hospitals to take advantage of economies of

scale, the availability of expensive equipment, and ease of communication. The middle and upper-income citizens have been able to take advantage of this phenomenon because their private physicians are able to refer them to the specialists in the hospital complex. The poor, however, have less accessibility to the hospital services. In addition, there has been a tendency for many hospitals to leave the central city and relocate in areas more inaccessible to the inner-city poor.

These two factors have resulted in a vacuum in available health care services within many inner-city neighborhoods. There are few private physicians in these areas and the poor do not have access to the specialized services in the hospital complexes. If they seek care at all, many of the poor must continue to rely on the outpatient departments of large public hospitals. These departments, according to one observer, " . . . still retain some of the attributes of their predecessors, the eighteenth-century free dispensaries. They are crowded, uncomfortable, lacking in concern for human dignity. . . ."[74]

The trends in medical care have also resulted in the fragmentation of services into preventive, curative, disease-oriented and research programs. That is, there has been an increased emphasis on education and research and less on community and social medicine and preventive health services. Once again, these developments have served the non-poor well because they have access to the services through their private internists and general practitioners. The poor, however, who must rely on the impersonal, non-continuous services of out-patient departments, are virtually excluded from the benefits of specialized services. At a time when health care is becoming more

specialized and impersonal, the poor require personalized services which treat them as whole people with social, physical, and mental health problems.

The factors working to isolate the poor from adequate health care have resulted in an increased awareness of the need for major changes in and the restructuring of the health care system as it relates to the poor. Neighborhood health centers have the potential for alleviating many of the defects in the system by being conveniently located and " . . . providing all types of care for the entire family . . . especially in those areas where the community must organize care for a high proportion of families in lower socioeconomic groups."[75]

The neighborhood health center is designed to fill the existing void in health services in low-income, inner-city areas. It is primarily designed to be accessible to the poor who, because of the withdrawal of health care providers from their neighborhoods, are not receiving adequate health services. The center is also designed to overcome the obstacles of immobility and a lack of understanding of the existing health care system by providing the services in a familiar, convenient setting.

There has been criticism, however, with a policy followed in most recent health center developments of designating a specific geographic area and population to be served. All those living outside of the designated area, whether in need of health care or not, are excluded from the benefits of the center. This policy is seen as self-defeating. In reference to such policies, one official states that " . . . requirements that are established for the ease, perhaps

of administration, without regard for the need of the people are to be deplored--and changed."[76]

Such policies would seem to have been necessary, however, in light of the limitation of funds placed on the demonstration health center projects and the need to define and later evaluate the health services required for a specific population. So while the need was great to deliver health care to the poor, the goal of the program was to evaluate the utility of the neighborhood health center concept as a mechanism for health care delivery. As a matter of fact, many of the health centers handled heavier patient loads than anticipated. Had they opened their doors to anyone, they would have been overwhelmed and the care provided would perhaps have been of poorer quality then that previously available. In addition, it would have been difficult if not impossible to evaluate the feasibility of the neighborhood health center concept.

Wide Range of Services

While the neighborhood health center is primarily designed to meet the health needs of the inner-city poor, it is also designed to attack their social problems. Indeed, it is difficult to separate the health and social problems, for among poverty populations, the two are interdependent:

> Ill health, joblessness, illiteracy, delinquency, family disorganization, and the many other components of poverty are inextricably interwoven. A program directed against any one of these factors can be perceived as an entering wedge against all the others. In these terms, the neighborhood health center provides more than therapeutic intervention in disease processes. It is a method of social intervention in the more encompassing processes of deterioration and decay which underlie poverty.[77]

The health centers of the early twentieth century recognized the special health and social problems of the poor immigrants. The similarity of that "culture of poverty" and the one found in the present inner city among largely black populations was pointed out by George James who stated that the separateness of the poor from society " . . . is one of the most important factors of urban poverty. The question of communication between the urban poor and those who are not poor often seems more like contact between two foreign nations than between people in the same city."[78] This separateness requires a wide range of special services to adequately serve the urban poor. The comprehensive care offered is " . . . designed to eliminate episodic and fragmented services by providing all necessary diagnostic, therapeutic, preventive, and rehabilitative services for ambulatory (non-institutionalized) patients."[79]

Health care, particularly for the poor, has traditionally focused on responding to crisis situations; that is, a disease was not detected or treated until it interfered with the functioning of the individual. This led to an emphasis on therapeutic or curative medicine. The health center, of course, offers such therapeutic services. One of its principal aims, however, will be the provision of preventive health services designed to prevent disease or detect and treat it before it reaches the crisis stage. The importance of preventive medicine was pointed out by Sigerist who stated that medicine is more a social than a natural science because its goal is social, and that "Medicine, by promoting health and preventing illness, endeavors to keep individuals adjusted to their environment as useful

and contented members of society."[80]

Preventive health care may be classified into three types. Primary preventive care is designed to prevent the occurrence of a disease through physical examination or through immunization for specific disease. Secondary preventive care is aimed at detecting disease before it has progressed to a serious stage. Tertiary preventive care involves the rehabilitation of patients recovering from an illness and is designed to allow them to return to a normal level of functioning and to prevent a recurrence of the disease.[81] The neighborhood health center concentrates on providing primary and secondary preventive care but does not always provide rehabilitative services except possibly through home visits by visiting nurses in the center's outreach program.

The comprehensive care offered by a health center should be complete in that is provides a patient with whatever he needs at the center or can refer him elsewhere for more specialized services. The comprehensive services can be placed in three categories: Health Education, Specific Prevention, and Early Diagnosis and Treatment.[82]

Health Promotion. The health center should have as its goal the prevention of disease and the promotion of health. These programs should involve environmental protection of the neighborhood, health education programs, and family planning services.

(a) The health center should promote healthy conditions in the neighborhood, in individual households, and in occupational environments. The neighborhood health center is usually not capable of undertaking large-scale programs in these areas, and perhaps it should not

attempt to. It can, however, serve as a monitor for the neighborhood by reporting specific problems to relevant agencies. For example, if there are areas of deteriorating housing, they can be reported to the local building inspection or code enforcement unit. If garbage is creating a hazard because it is not being collected, the center can inform the appropriate authorities and push for an improvement of the situation. A rat problem can be reported to the public health unit for action. A drainage problem causing a mosquito infestation can be reported to the local water and sewer department. If a factory in the neighborhood violates Federal occupational noise level standards, the center can notify the appropriate agency. The center, therefore, serves to promote and enhance the general level of environmental quality in the neighborhood not so much through attacking a specific problem directly, but by functioning as an advocate for the area. The center monitors the neighborhood and initiates corrective measures by responsible agencies.

(b) The center can promote health more directly through general and specific education programs designed to establish positive health habits and eliminate harmful habits. Education programs dealing with nutrition, smoking, alcoholism and drug addiction, physical fitness, and biological functions can be conducted at the center. Personal health habits are of extreme importance in health maintenance, and low-income citizens are notably lacking in their knowledge of such self-care procedures. This lack of knowledge should be taken into account in the designing of the education programs: "Health programs should focus on highly specific health practices, for these can be

learned and practiced routinely without comprehension of complex or abstract principles of health."[83] More personalized and effective education programs can be carried out by visiting nurses or health aides in home visits as part of the center's outreach program. The individual or family social environment is an important factor in health and " . . . nothing can quite take the place of a home visit by a professional person in assessing and perhaps assisting in ameliorating the effects of an unsatisfactory home situation."[84]

Mental health programs are also vital in promoting health. In fact, the mental health educational programs and psychiatric counseling and referral services may be the most important service provided by the center. The poor are under a great deal of tension in their daily lives, and the psychic stress they endure often manifests itself in physical symptoms. A 1966 poll by Louis Harris made the following conclusion: "The poverty-stricken, across the board, tend to be more 'worried and nervous,' more 'lonely and depressed,' less able to sleep, far more 'exhausted,' with less appetite, far more 'faint and weak,' and more overly tense (than the general population)."[85]

Mental health programs and services should seek to promote intellectual and emotional development among neighborhood residents by helping them to cope with environmental stress which interferes with daily functioning. Such services are needed to a certain extent by almost everyone seeking medical care and should therefore be a major part of preventive care and treatment. The Harris poll revealed a desire among the poor to have psychiatric services provided in the neighborhood medical center. Such services would provide a " . . .

convenient way in which their own doctor could refer them for a preliminary talk with a trained psychiatrist, without a commitment for extended therapy or treatment. . . ."[86] The poor person would therefore feel more at east in discussing his mental difficulties with his physician.

The best location of these services is open to question. Some observers feel that counseling should be available in the health center itself. There has been a recent trend, however, toward the decentralization of mental health services to several access stations throughout the neighborhood which are more accessible. At any rate, mental health programs are an important part of the services provided by the health center.

(c) The center can further promote health in the neighborhood through the provision of family planning services. Counseling should be available on the problems of sexual and marital adjustment which are common among the poor. Of course, information on birth control measures should be a major part of any such education program so unwanted pregnancies can be prevented.

Infant and child care programs should also be offered at the center. These programs are of particular importance in light of the high infant mortality rates and child health problems among the urban poor, problems whose social and behavioral aspects are of greater importance than their biomedical aspects. Consequently, " . . . the effectiveness of health services dealing with such problems must be assessed against consumers' behavior as well as against such traditional measures as the number of people treated or reduction in

morbidity or mortality among consumers."[87] Educational programs in infant and child care are designed to influence "consumers' behavior" so that health problems can be avoided. Educational programs are an essential part of any effort to promote better personal health care. Sigerist points out the value of health education:

> This involves more than providing health information, since it is principally concerned with effecting useful changes in human behavior. The goal is the inculcation of a sense of responsibility for avoiding injury to the health of others. On behalf of children, this implies encouragement of those child-rearing practices that foster normal growth and development. . . . It includes the nurturing of health-promoting habits, values, and attitudes that must be learned through practice. . . . Another goal is the achievement of an understanding of the appropriate use of health services.[88]

Specific Prevention. While the neighborhood health center should make a general effort to prevent health problems through education programs, it should also offer preventive services to control specific problems.

(a) Immunizations should be available for prevention of measles, poliomyelitis, diphtheria, pertussis (whooping cough), tetanus and other diseases. Such services are a part of the primary preventive medicine program of the center.

(b) Nutritional and dietetic programs should be incorporated in center services. Patients should be provided with specific information about proper nutrition in the educational programs and should be provided with special diets to meet personal needs.

(c) The health center should contain a pharmacy offering a full range of drugs.

(d) The center should provide various occupational health programs.

Early Diagnosis and Treatment. The health center should provide services for the diagnosis and treatment of illnesses among the population it serves.

(a) The diagnosis and treatment services should include regular complete physical examinations for all segments of the population. Prenatal, neonatal, and well-baby programs should be offered to insure the normal growth and development of infants. Preschool and school-age pediatric services should also be available. Adults should be able to receive complete physical examinations for whatever reasons, whether self-sought or for employment or insurance purposes. The center should also provide comprehensive dental services, an essential facet of any comprehensive care program but one which has often been omitted in health care services for the poor (usually because of the relatively high cost of such services.) The health center should also provide in-house specialists for referral in such areas as obstetrics and gynecology, ophthalmology, otolaryngology, radiology, and pathology.

(b) Diagnostic and treatment programs might also be oriented toward the detection of specific diseases including the following: venereal disease, diabetes, tuberculosis, cancer, hypertension, coronary heart disease, rheumatic and congenital heart disease, and mental illness.

(c) Mass screening programs with a non-specific orientation might also be conducted by the center. By employing such techniques as multiphasic screening, large numbers of people can be examined or tested with emphasis on certain parameters as general indicators of an individual's health status:

Immunologic: susceptibility to measles, poliomyelitis, smallpox, diphtheria, pertussis, tetanus, etc.

Anatomic: lumps in the breast, obesity, lesions disclosed by chest X-ray, dysplasia, and cerivcal cancer.

Chemical: elevated blood-glucose, cholesterol, triglycerides, uric acid, low hemoglobin, proteinuria.

Physiologic: elevated blood pressure or intraocular tension, electrocardiographic abnormalities, diminished respiratory capacity.

Behavioral: agitation, depression, cigarette smoking, excessive use of alcohol and other drugs.

The health promotion or preventive health aspects of such mass screening programs was pointed out by Breslow: "Medical advances permitting surveillance over such items . . . now make it feasible to convert the whole health care system from a complaint-response focus to a health-maintenance focus."[89] The health center should ordinarily contain its own laboratory facilities adequate to handle all such tests performed at the center.

Mechanisms to Promote Continuity and Prevent Fragmentation

Ambulatory health care for the urban poor as offered by hospital outpatient departments is characterized by impersonal and discontinuous service. Long waits and crowded conditions at these facilities might be tolerable if the care provided could offer emotional reassurance and comfort as well as adequate health care services. The neighborhood health center has as one of its goals the provision of health care on as human and personal a scale as is possible under budget constraints which limit available personnel and space. The health center also

attempts to prevent discontinuity between levels of care (e.g., between the health center and the hospital) and to reduce the fragmentation of specialized services which, because of their dispersed character, have been largely inaccessible to the immobile poor.

Health Care Teams. The method through which the health center attempts to provide personal and continuous care is the health care team. The traditional "family physician" or "country doctor" who was a friend as well as a professional is a thing of the past, an institution which was fine in its day but is no longer practicable. The crush of population growth and the increased complexities of rendering medical care have made it difficult for one to receive genuinely personal care. However, it would seem that a basic requirement of effective medical care would be the establishment of a one-to-one relationship between a physician and a patient. Through such a relationship, the patient would gain some satisfaction and assurance from seeing a familiar face upon each visit to the health center rather than encountering someone different on each trip to a hospital outpatient department.

The health care team is designed to foster a one-to-one or continuous relationship between the patient and a physician. The team is also designed to meet the basic needs of the patient, both social and physical: " . . . the center's program is not broken down into a multitude of specialty clinics, but instead there is one general program for all patients."[90] The exact composition of each primary team varies from center to center but generally consists of a physician (usually an internist or a general practitioner), a pediatrician,

nurse(s), possibly a dentist, a nurse practitioner or neighborhood health aide (usually a neighborhood resident), and perhaps a social worker. Patients are usually assigned to a particular health team on a geographic basis; that is, a team is assigned responsibility for a certain area and all patients living in that area are assigned to that team.

The health care team is designed to function much like the "family physician" of past years by providing the physical and, perhaps more importantly, the emotional needs of the patient. The team members take some of the work load off of the primary physician so that the heavy patient load can be handled. While the nurses and paraprofessionals are essential to the effective functioning of the team, the most important member and the key to the utility of the team concept is the primary physician who " . . . can most easily establish the personal confidence so important in any physician-patient relationship, and they fulfill most effectively an essential function in comprehensive care--referral of patients to ancillary services."[91]

Another aspect of the health team approach is its emphasis on "family medical care," or the goal of treating family units. It is hoped that entire families can be registered as single units with every member of the family under the care of the same physician and team. The physician can thus coordinate all health care for that family. It is also hoped that family care records can be developed dealing with all aspects of the family including information about social and psychological problems as well as medical histories. This feature is further evidence of the effort to reformulate the personal care model provided

by the "family physician" in a contemporary setting.

Referral System. The health center can further provide continuity between the levels of care such as between acute and chronic care facilities through its referral system. The center should be sponsored by or have an affiliation with a hospital which can provide back-up referral services for specialized care not available at the health center, as well as inpatient care. The primary team physician or some other team member should keep track of the patient to assure that the referral takes place smoothly, much as a non-indigent patient would be carefully followed by his private physician. In addition, the team should handle referrals to specialists not located at the back-up hospital. The fragmentation of such specialized services has been a major obstacle to the poor who lack the mobility and understanding of the health care system to take advantage of them.

The health center should also foster continuity between the termination of institutional care and the return to home or work through "follow-up" procedures. Visiting nurses or neighborhood health aides can make home visits to assure that the patient is making satisfactory progress. These home health workers are usually recruited from the neighborhood so that they have an understanding of the area and are more likely to be accepted by the residents. Such "outreach" services may result in the more efficient use of health facilities as well as be more convenient to the poor:

> Because the Center's services are comprehensive, a patient is more likely than in the past to be treated at the Center or in his home than at the hospital. Those who need hospitalization will have their hospital stay shortened, because the Center can provide the necessary follow-up care. Hospitals will be utilized more discriminately. There will be fewer instances of patients coming to

> a hospital emergency department for after hours treatment of non-emergency illness; and fewer instances of patients neglecting an illness until it becomes a valid emergency and needs immediate hospital attention.[92]

Employment Opportunities for Neighborhood Residents

As mentioned, the neighborhood health center is designed not only to serve as a health care delivery mechanism, but also as an instrument of social change, a method of influencing the socioeconomic and even the political aspects of the lives of the urban poor. One of the chief means by which the health center concept aims to achieve this goal is through the employment of neighborhood residents (indigenous workers). The center usually operates a training program to help the poor adjust to working at the center. There is often a health care advancement program which is designed to prepare these employees for relocation to other jobs in the health field.

Most of the jobs available at the center are unskilled and semi-skilled in such areas as administration and records; social services; and medical, dental, and pharmaceutical assistants. A 1971 Office of Economic Opportunity report stated that about 6000 neighborhood residents were employed in fifty neighborhood health centers, or about 50 percent of the total staff employment. It was also estimated that 20 percent of project expenditures went to community residents.[93]

The health centers have also formulated a new category of health worker, the "neighborhood health aide" or "family health worker." These workers go into the homes to provide outreach services, educational guidance, and follow-up care for patients who have received treatment or who have missed appointments. The training such a family

health worker receives places " . . . a strong emphasis . . . on patient education, case finding, the preventive aspects of medical care, and the emotional factors influencing illness."[94] The fact that these workers reside in the neighborhood and are familiar with the problems of living there makes them more acceptable to the residents than someone from another neighborhood or socioeconomic level.

Geiger and Cohen pointed out the value that the employment of neighborhood residents can play in positively influencing their lives:

> Since many of the new programs in health care are directed toward the poor and employ many program constituents, the health care system has the opportunity to provide a new means of social mobility, as the urban political structure has for earlier generations of the poor. Beyond providing jobs at the lower levels of the hierarchical structure, provision should and can be made for the entry of people previously excluded into newly developing careers as well as traditional health professions.[95]

Neighborhood Participation

Because the most recent wave of neighborhood health centers was developed as a part of the Community Action Program under the Office of Economic Opportunity, there was an effort to encourage the involvement of the neighborhood residents in the planning operation of the center. The citizen participation aspects of earlier Federal programs such as urban renewal and the Workable Program for Community Improvement had resulted in the involvement of business and civic leaders with city-wide interests whose role was to persuade neighborhood residents that a particular program would be to their benefit.[96] With the "maximum feasible participation" called for in the Community Action programs, however, there was a genuine effort to encourage the direct influence of neighborhood residents on various programs.

There has been reluctance among health professionals to allow

any laymen, particularly the poor, to have a significant voice in the delivery of health services they receive. There is, however, a tradition of citizen participation in health planning in the United States. Citizens have served as volunteers in health and social welfare agencies promoting health education and legislation, and "Citizen boards have developed and administered health care facilities and services such as hospitals, visiting nurses' associations, and family planning agencies."[97] Moreover, "the political realities of adequate health care demand public participation because the issues go far beyond technical medical questions into matters of public policy."[98]

As mentioned, middle and upper-class citizens have been able to adjust to the changes in the health care system because they have the awareness, mobility, and financial resources to take advantage of the available services. They have been able to influence the system through their economic and political power. However, "The poverty populations have not had this opportunity and thus must find other methods for guaranteeing that services meet their needs."[99] A 1966 editorial in the American Journal of Public Health also recognized the importance of citizen participation in the planning and delivery of health services:

> The citizen is now demanding to be heard and, realistically, has a better concept of many of the health services he desires, and possibly even requires, than do those professional health workers who, with all of their preoccupation with health standards, are often unfortunately less familiar with the organization of the neighborhoods to be served and with the motivation of the people affected.[100]

The role of citizen participation in neighborhood health centers was spelled out in the 1967 OEO guidelines. They suggest that neighborhood councils or associations be formed to allow target area residents

to " . . . participate in such decisions as the precise location of the program's services, the time they shall be available, the establishment of program priorities and matters relating to employment policy, and the establishment and implementation of eligibility criteria."[101] Such councils were to be advisory bodies only with little or no voice in policy making. In the majority of the centers, there was a "top-down" form of sponsorship by which a hospital or medical school initially had full control of the center. After a smooth start, such a center would often encounter conflicts with the neighborhood over control of the center.

As experience in the health center program was gained, the OEO revised its guidelines in 1968 to define the role of the advisory councils:

> The neighborhood council shall participate in such activities as the development and review of applications for OEO assistance, the establishment of program priorities, the selection of the project director, the location and hours of the center's services, the development of employment policies and selection of criteria for staff personnel, the establishment of eligibility criteria and fee schedules, the selection of neighborhood residents as trainees, the evaluation of suggestions and complaints from neighborhood residents, the development of methods for increased neighborhood participation, the recruitment of volunteers, the strengthening of relationships with other community groups, and other matters relating to project implementation and improvement.[102]

These OEO guidelines prompted one observer to assert that "The neighborhood health center is perhaps the most extensive commitment to community involvement in the delivery of health care in U.S. history."[103]

Neighborhood residents did not view the situation so favorably and were not satisfied with their advisory councils. There were problems inherent in the OEO guidelines because they were general and left much of the responsibility of interpretation and application to

the local community action agency. Perhaps this was unavoidable, but it led to many conflicts between the community, the sponsors (hospital or medical school), the community action agency, and the OEO, not over health care matters, but over who was to have control over administration and policy making.[104]

The more militant elements in many neighborhoods took advantage of the situation to push for greater control of the health centers. They advocated the participation of neighborhood residents on governing boards which would foster community control through the allocation of all " . . . important planning, policy and operational responsibilities to broadly representative neighborhood health boards with locally responsible neighborhood health administrators."[105]

Many neighborhood residents viewed this as an opportunity to have more influence on policies affecting them. Control of the governing boards of health centers would give them a chance to formulate policies and plans, control the hiring and firing of all personnel, and approve financial proposals. More importantly, they saw " . . . the introduction of money for health improvement as a means to community development and a larger-scale role in public decision making."[106] Control of the operations of a health center board could possibly lead to the development of a neighborhood government and a decentralization of power.

An incentive toward the movement to greater neighborhood control was provided by shifts in OEO structure and policy under the Nixon Administration which were designed " . . . to circumscribe the powers of Model Cities neighborhood residents and to transform the

Office of Economic opportunity from an action to a research and experimental agency . . . (with) less diversity in citizen participation policies."[107] There has also been an increasing emphasis on experimenting with city-wide health networks and health maintenance organizations and less on neighborhood control. As a result, there has been a tendency for neighborhoods to try to get out from under OEO and more recently HEW control.

Despite the push by some neighborhoods, there have been few cases of residents gaining complete control of a health center. The trend is definitely in that direction, however. The newer centers have involved more community participation from the start while the older centers have been transferring control and power to neighborhood representatives.[108] The advisory boards of the early stage of the modern health center era have given way to neighborhood participation on policy and governing boards and may lead to complete community control. As this shift in control has occurred, however, OEO and HEW have begun to withdraw from participation in the older centers and have let it be known that Federal money will soon be cut off. In other words, if the community controls the center, it will have to find a method for the center to become self-financing.[109]

However, there are those who believe that neighborhood residents gain little by having more control over the operations of a health center. For example, Steven Jonas stated that gaining administrative control of the center will not influence the three building blocks of a health institution: the capital budget, the expense budget, and the supply of staff. These are controlled at the state and

national levels and the inability of the poor to influence decisions regarding them will result in community control becoming "community administration."[110] According to Lawrence Howard, this will constitute neighborhood control of "a powerless operational base" and " . . . a successful health care system implies coordination of medical and health resources in a meaningful region; and control over the system requires control on a regional, not on a neighborhood basis."[111]

The long-term implications of community or neighborhood control of health centers is certainly open to conjecture. There has been and remains, however, a definite commitment in the health center concept to community involvement in the planning and operation of the centers. This commitment is in keeping with the center's role as an instrument of social change as well as a health care delivery mechanism.

The Planning Process for the Center

This section examines the planning process involved in the organization of a neighborhood comprehensive health center. In any city of significant size, there may be several neighborhoods in the recommended population range of 20,000 to 30,000 which would benefit from the services of a health center. In many cases, however, the restriction of a limited budget will necessitate the selection of only one or two such areas or sites for centers. In this discussion of the planning process, it will be assumed that the neighborhood has been selected. In the process of selecting the target neighborhood, the criteria discussed below employed in the planning for a specific center may be applied to all neighborhoods under consideration for comparison purposes. The five steps in the planning process are as

follows: (1) determination of the health care consumers; (2) evaluation of the health needs and the existing health care system; (3) identification of the services to be provided; (4) site selection, and (5) transportation analysis.

Determination of the Health Care Consumers

The first step in planning the health center is an evaluation of the target population or the consumers of the health care services. Various socioeconomic data must be obtained so that the nature of the target population can be analyzed and identified.

Population Size. The size of the population in the neighborhood must be determined. This information can be derived from the decennial census. (This dependence on census data points up the need for a close correlation between the neighborhood boundaries selected and the census tract lines.)

Age Groups. The age groups of a neighborhood are important. The type and scope of services offered at the center are dependent on the age characteristics of the population. For example, neighborhoods with a predominance of children under fifteen and adults over sixty-five (common in inner-city neighborhoods) require more health services than those in the fifteen to sixty-five group. These age groupings are also available in the census data.

Density. The distribution and location of the target population must be analyzed. Identification of population concentrations and densities are especially important in the process of site selection for the center because of the goal of maximum accessibility. This information is available in the census data.

Racial Composition. The racial composition is important in assessing the neighborhood. An area with a predominantly black population will usually have different health problems from a neighborhood with a significant white population and will require different types of health services. Racial composition data can be obtained from the census.

Sex. A population breakdown by sex can be obtained from the census. Such information is important in understanding the population and in designing health center services. For example, the size of the female population will determine the level of prenatal, postnatal, and well-baby services that will be necessary.

Economic Classifications. The economic characteristics are also of importance in developing an understanding of the target population.

(a) The income levels of the residents can be important for financial planning because they can be used to determine what portion of the population would be able to pay (usually on a sliding scale) for the center's services. Conversely, the information can reveal what proportion of the population will be unable to pay and will require free services.

(b) It is necessary to determine what proportions of the population are eligible for Medicare, Medicaid, and third party insurance coverage in order to evaluate the potential financing problems of the residents. Everyone over sixty-five is eligible for Medicare and everyone under the accepted poverty level is eligible for Medicaid. Statistics on disability, income, and the number of dependents for

individual families are available from welfare offices and family and children services departments. The proportion of the population eligible for third party coverage (Blue Cross, Blue Shield, and other insurance programs) can be obtained from the records of the outpatient department at the appropriate hospital.

(c) From the socioeconomic data accumulated, it is possible to make an estimate of the anticipated resident participation in the health center. This can be done by evaluating the characteristics of the population and the ability of those above the poverty level to finance health care services from the center or from other sources.

Other Socioeconomic Indicators. There are other indices which can be of value in understanding the character of the target population and will help in meeting the residents' needs:

Index	Source
unemployment statistics	state labor department
educational levels and drop-out rates	local school system records
number of renters and homeowners	census data
school-age illegitimacy	county birth records
housing conditions, overcrowding	local planning agencies
child neglect	county juvenile court
arrests (burglary, robbery, assault, etc.)	police department records
homicides	police department records
other violent deaths (accidents)	county medical examiner
mental health problems	hospital psychiatric wards, hospital mental outpatient records
suicides	county medical examiner
alcoholism	local rehabilitation centers and police arrest records
drug addiction	local rehabilitation centers and police arrest records

The value of socioeconomic indicators in evaluating the characteristics of the target population can be seen in the conclusion

of a San Francisco study. Of twenty health indicators used in identifying high risk census tracts (areas with the greatest health and social needs), only four proved to be both available and useful. Of nine socioeconomic indicators, however, seven proved to be both available and useful. So, in this study anyway, the socioeconomic indicators proved to be more useful in identifying problem areas than the health indicators.[112]

A Note About Census Data. Census data can obviously be of use in evaluating the target population. There are limitations in its use, however. Because the census is taken every ten years, its value may be lessened in areas undergoing rapid population changes, a situation common in many inner cities. The San Francisco study arrived at the following conclusion:

> It appears most practical to identify high-risk areas by a consideration of (socioeconomic) indexes derived from decennial censuses, supplemented by an examination of more recent changes in those indexes which can be obtained in intercensal years. Indexes for which it is advisable to pool data for more than one year might be computed at three-year intervals, or alternatively, as annual averages of the three-year rate.[113]

Evaluation of Health Needs and the Existing Health Care System

The next step in planning the health center is to determine the health problems of the target population and to evaluate the existing health care services available to them.

Evaluation of Health Needs. The health problems of the target population should be determined so that adequate services can be offered at the center. As mentioned, the health problems of the poor inner-city residents are greater than the nation as a whole. Hypertension, diabetes, and the lack of prenatal and infant care are

major problems.

One method for determining the problems of a specific population is to consult the local health care providers. Physicians and nurses who see the residents daily obviously have an excellent understanding of their health problems. Because most inner-city neighborhoods lack the services of private physicians, the health care providers to be interviewed are those staffing the local public health clinic and the outpatient clinics of the hospital serving the target population.

Another possible method to evaluate the health problems is the survey. In this manner, the residents can be consulted personally concerning their health problems. (Relevant data which the survey should gather are listed in Table 1.)[114] Other data to be gathered would include reasons for not seeking health care, problems encountered in seeking care, and the perceptions of health care professionals. In addition, information concerning home health care (home remedies, friends with nursing experience) would provide an indication of the importance of these factors. Surveys are expensive, however, and are often resented by the residents who may consequently form a negative attitude toward the health center before it opens. It might be necessary to pay each respondent for the interview as was done in Binghamton, New York, in a health center survey conducted by the medical society, health department, and the local health planning council.[115]

The survey should also be used as an entering wedge into the health problems of the residents. Often the problem cases detected are lost through a lack of follow-up and there is a missed opportunity for case-finding, health education, and prevention which can be

Table 1. Health Data to be Derived by Survey

General Medical Information

Usual Source of Care
Usual Source of Care--Type
Usual Source--Private Doctor, Place of Visit
Usual Source--Specialist
Traveling Time to Source of Care
Most Trusted Source
Most Trusted Source--Private Doctor, Place of Visit
Long-Term Illness with Activity Limitation
Chronic Illness Which Limits Kind and Amount of Work for Persons Over 18
Chronic Illness and Unable to Work Now or for 3 Month Period
Time Since Physician Last Seen About Chronic Condition
Taking Regular Medication for Conditions
Medication Prescribed by Doctor
Medication not Prescribed, Bought in Drugstore

The Most Recent Illness

Perceived Severity at Onset of Most Recent Illness
Primary Recommendation by Spouse
Recommendation by First Other Person in Household
Doctor Seen or Called During Most Recent Illness
Medication Used if Doctor Not Seen
Medication or Shots Received During First Visit
Treatment, Tests, X-rays During First Visit
Return Visit Recommended by Physician
Hospitalization Suggested by Physician
Number of Nights in Hospital for Most Recent Illness
Number Undergoing Surgery During Hospitalization for Most Recent Illness
Days in Bed or Indoors
Interval Since Last Physician Visit
Total Physician Visits in Past Year
Location of First Call or Visit with Physician for Most Recent Illness

Pregnancy Information

Now Pregnant
Number of Months Pregnant Now
Doctor Seen About Current Pregnancy
Number of Months Pregnant When First Saw Doctor--Current Pregnancy
Source of Care for Current Pregnancy
If None Yet, Probable Source of Care for Pregnancy
If Not Pregnant Now, Any Pregnancy in Last 12 Months
Type of Pregnancy Termination
Number of Months Pregnant at Termination

Table 1. Continued

Pregnancy Information (continued)

Source of Care for This Terminated Pregnancy
Number of Months Pregnant When First Saw Doctor--Terminated Pregnancy
Total Number of Doctor Visits This Terminated Pregnancy
Postpartum Visits, Terminated Pregnancy
Number Inpatient Admissions in Last 12 Months (Excluding Most Recent Illness)
Hospitals Used for Most Recent Hospitalization
Number Eligible for Free Care at Public Hospital
Number 65 or Older Enrolled in Medicare
Number Having Medicare Identification Card

Dental Health Information

Number Enrolled for Doctor Insurance Under Medicare
Visits to Dentist/Dental Assistant in Last 12 Months
Place--Dentist or Dental Assistant Seen Last Time
Traveling Time to Dentist
Dentist or Dental Assistant Checked, X-rayed, Cleaned Teeth Last Visit
Dentist or Dental Assistant Fixed or Filled Teeth at Last Visit
Dentist or Dental Assistant Repaired Bridge Work at Last Visit
Dentist or Dental Assistant Pulled Tooth or Teeth at Last Visit
Number Paid for Last Visit to Dentist or Dental Assistant

Immunization Record

Polio Vaccine by Mouth
Injections Against Polio
Injections Against Measles
Injections Against Diphtheria
Number of Diphtheria Shots

Emotional Problems

Often So Sad and Blue Can't Carry on Usual Activities
Often Nervous, Tense, and on Edge, Can't Carry on Usual Activities
Minister Seen About Personal Problems
Doctor Seen About Personal Problems
Chiropractor Seen About Personal Problems
Psychiatrist or Psychologist Seen About Personal Problems
Social Worker Seen About Personal Problems
Lawyer Ever Seen About Personal Problems
Faith Healer/Prophet Seen About Personal Problems
Reported Chronic Conditions and Impairments with Activity Limitation

initiated once the health center is operating. The survey can also be used as a referral system for residents with health problems as long as the referral forms are independent of the questionnaire to protect the confidentiality of the survey.[116]

If a survey is not possible, there are numerous health indices which can be used in determining the level of health among the target population, most of which can be obtained from health department and hospital records:[117] maternal mortality, inadequate prenatal care, fetal mortality, neonatal mortality, postneonatal mortality, childhood mortality, incidence of prematurity, immunization levels, pertussis (whooping cough) incidence, tetanus incidence, poliomyelitis incidence, typhoid fever incidence, tuberculosis incidence, venereal disease incidence, cases of child abuse, school lunch usage, selective service rejection, and absenteeism at school or work.

There will be differences in the usefulness of these indicators from city to city and from neighborhood to neighborhood. In the San Francisco study mentioned previously, the most important or useful of these health indicators were the levels of inadequate prenatal care (live births with no prenatal care, or prenatal care only in the third trimester per 1000 live births); fetal mortality (infants weighing over 400 grams born dead per 1000 live births); the incidence of prematurity (infants born alive weighing 2500 grams or less at birth per 1000 live births), and the incidence of tuberculosis (the reported cases per 10,000 population).

Evaluation of Existing Health Care System. In order to plan for an effective health center, an evaluation of the existing health

care system must be made to determine its inadequacies. The best method for evaluation is to ask the residents themselves about their sources of health care and how they could be improved. As mentioned, however, such surveys are expensive and are often unpopular with the residents. An alternative is to consult with the known health care providers such as the staffs of public health clinics and outpatient departments of the local public hospitals. Another method is to consult several community leaders who are familiar with the problems of neighborhood residents. Through such discussions the extent of the fragmentation and discontinuity of the available services can be identified.

Identification of the Services to be Provided

From an evaluation of the health problems of the target population and the existing health care system, it can be determined what type and scope of services the health center should offer (discussed earlier in this chapter). There are no general rules or standards which can be used in the determination of the services to be provided because so little research and investigation has been conducted. Most health center projects have operated by a "seat of the pants" method of making rough estimates of needed services before beginning operations and making adjustments as needed after opening. (Because of the individuality of each neighborhood and target population, this may sometimes be the most realistic and effective means of service provision.) Despite the inexact nature of making such a determination, however, there are certain services which any comprehensive health center should provide:

1. Physician Services
2. Nurse Services
3. Radiology Services
4. Laboratory Services
5. Dental Care
6. Mental Health Services
7. Home Health Visits (nurse, social worker, health worker)
8. Pharmacy
9. Occupational Therapy
10. Referral for Hospitalization and Extended Care

As mentioned, the specific health problems of an area will determine the scope of these services. For example, in many inner-city neighborhoods, there is an almost total lack of dental care available. Consequently, a health center in such an area might be planned to provide adequate dental services in anticipation of a heavy demand or need for such services. Many inner-city neighborhoods also lack adequate opthalmological services which the health center should therefore provide. Mental health is also of extreme importance to the urban poor: "Today there is increasing concern with conditions such as asthma, peptic ulcers, and ulcerative colitis, as well as with psychosomatic diseases. These ailments reflect increasing psychosocial pressures."[119] The mental health component of the neighborhood health center should be considered a major aspect of the center's services.

Site Selection

The most important factor related to accessibility is the location of the center in relation to the population distribution in the target area. The distribution of the population should be analyzed and the center located as close as possible to the major population concentrations such as public housing projects. In addition, the center should be in a visible location because maximum exposure to

the residents will increase their use of the facility.[120]

It is often difficult to locate a suitable site for a health center in an urban neighborhood. If an existing structure is to be used, it is often difficult to find one containing 20,000 to 30,000 square feet in sound condition which is suitable as a health center. In the early OEO health center projects, therefore, storefront centers were opened in former groceries, schools, and warehouses. Such a method was used at the Montefiore Health Center which first opened in an old five-and-ten-cent store while a permanent facility was being renovated.[121]

The problem of finding a suitable structure was lessened when OEO rescinded its guideline prohibiting new construction of buildings for health centers. Now the problem is not finding a structure but locating a vacant tract of an adequate size in an acceptable location on which to construct a center, a task which may not always be easy in a highly developed urban neighborhood. The site must include enough room to allow for expansion of the facility and for parking space. Whether the center is in a renovated building or a new structure, it should have a beneficial effect on the neighborhood: "The neighborhood center not only utilizes the vacant space but gives to that space activity and usefulness that can affect positively the surrounding area."[121]

Security considerations are also important in locating the center. The site should be in an open area with substantial pedestrian traffic. If the center is to serve two neighborhoods of different racial character, it would best be located on the boundary of the two.

Placing the center within one of the neighborhoods would require residents of the other neighborhood to travel through an area of different racial character thereby possibly reducing their patronage of the center because of fears over the lack of security.

There are various environmental factors which should be considered in the site selection and development process.[122]

Existing Land Uses. Many inner-city neighborhoods have a mixture of land uses and have consequently experienced a deterioration in their environment. The health center should not be developed in an area with industrial uses which will be sources of noise or air pollution or generate large volumes of traffic which could pose a hazard to patrons of the center. The center should not be located in an area dominated by commercial uses for these can also have an adverse influence, particularly as a result of automobile traffic. However, some commercial uses should be convenient to the center to serve both the patients and the employees. In addition, activity created by commercial uses can also increase security by discouraging crime which might be more common in a secluded location.

Linkages with Surrounding Uses. There should be pedestrian access to surrounding land uses such as shopping centers, residential areas, employment centers, churches, schools, parks, and playgrounds.

Traffic and Transit. Discussed above and in the next section.

Zoning Regulations. Relevant zoning regulations should be consulted to be sure that the health center will be in compliance.

Utilities. There should be no major problems of availability of sewers, water systems, or gas and electric utilities in most inner-

city neighborhoods. The only problem may be with the age and condition of the utilities and the possibility that the sewers may handle both sanitary and storm sewage.

Natural Factors. In site analysis, there are several factors which should be considered:

1. Geologic data--to determine the depth of bedrock and other information which will affect development of the site.
2. Topography or slope analysis--to anticipate construction or drainage problems and to avoid steep inclines or steps which might hinder access to the center by the elderly or handicapped.
3. Hydrography--to anticipate drainage problems.
4. Soils analysis--to anticipate construction or drainage problems.
5. Vegetation--to preserve valuable trees, etc., as buffers or for aesthetic purposes.
6. Climatic factors--solar orientation and wind conditions.

Transportation Analysis

Because the health center is to provide accessible health care services to the urban poor, transportation is an important consideration in planning the center. In fact, in Los Angeles, Watts residents gauged their health status according to the dominant form of transportation available, the taxi: if one were "$10 sick," he was sick enough to pay that amount which was the typical taxi fare to the nearest hospital.[123] Prior to the opening of the health center in their housing project, the residents of Columbia Point in Boston were forced to travel for ninety minutes by bus and subway to reach

the nearest charity clinic--about the same time required for a flight from Boston to New York.[124]

The poor do not have access to private automobile transportation and must consequently rely on public transportation. Therefore, the health center must be located convenient to bus and subway lines. If the bus transportation in the neighborhood is inadequate, the sponsors of the center may serve as advocates for the neighborhood by petitioning the transit authority for improved service. Such services should provide adequate access for neighborhood social workers and paraprofessionals. The center should also be located near major transportation arteries to provide ease of access to employees who live outside of the neighborhood.

There are other important aspects of transportation as it relates to the health center. For example, there will be many citizens, including the elderly and the handicapped, who will be unable to reach the center unassisted even with the maximum level of public transportation. The center will have to provide transportation for such people by using station wagons or minibuses as has been done at the health centers in Denver.[125]

The center will also have to provide a mode of transportation from the center to speciality and acute services located at hospitals and extended care facilities. In addition, the center should provide unscheduled transportation service for individuals who are unable to reach the center by any other means. Perhaps it might be feasible to establish a dial-a-ride system in the neighborhood to serve the center. In addition, volunteers from neighborhood associations might serve as

drivers for the center's transportation system. At least one proposal has recommended the use of minibuses equipped with two-way radios coordinated by a dispatcher at the health center.[126] A related service might be the use of mobile health vans which would circulate throughout the neighborhood providing multiphasic screening services. Such a program would provide services to those who have not sought health care at the center or elsewhere. It would also offer an opportunity for a public relations effort for the center.

This chapter has presented a model of a neighborhood comprehensive health center and the various factors which must be considered in planning such a center. The following chapter will present a case study of the Atlanta Southside Comprehensive Health Center in an effort to examine the planning and development process for a specific health center.

CHAPTER V

A CASE STUDY: THE ATLANTA SOUTHSIDE COMPREHENSIVE HEALTH CENTER

The preceding chapters have dealt with the neighborhood health center concept and the physical and social considerations involved in the planning and development of such a center. References have been made to various health center projects throughout the nation in an effort to document their general experiences. A detailed examination of one health center would provide a more thorough understanding of the problems and opportunities involved. Consequently, this chapter presents a case study of the Atlanta Southside Comprehensive Health Center which was among the first of the OEO neighborhood health center projects in the nation.

The Atlanta Southside Comprehensive Health Center is located in the Price neighborhood south of the central business district and immediately south of Atlanta Stadium (see Figure 1). The Price area (named because of Price High School) consists of ten smaller sub-neighborhoods: Carver Homes, High Point, Joyland, Lakewood, Mechanicsville, Peoplestown, South Atlanta, The Village, Summerhill, and Washington Street. The population when the project was initiated numbered 28,500 of which two-thirds were non-white. The area was transitional with the white population rapidly declining. Several public housing projects and a substantial number of substandard and deteriorating housing is located in the target area. The project,

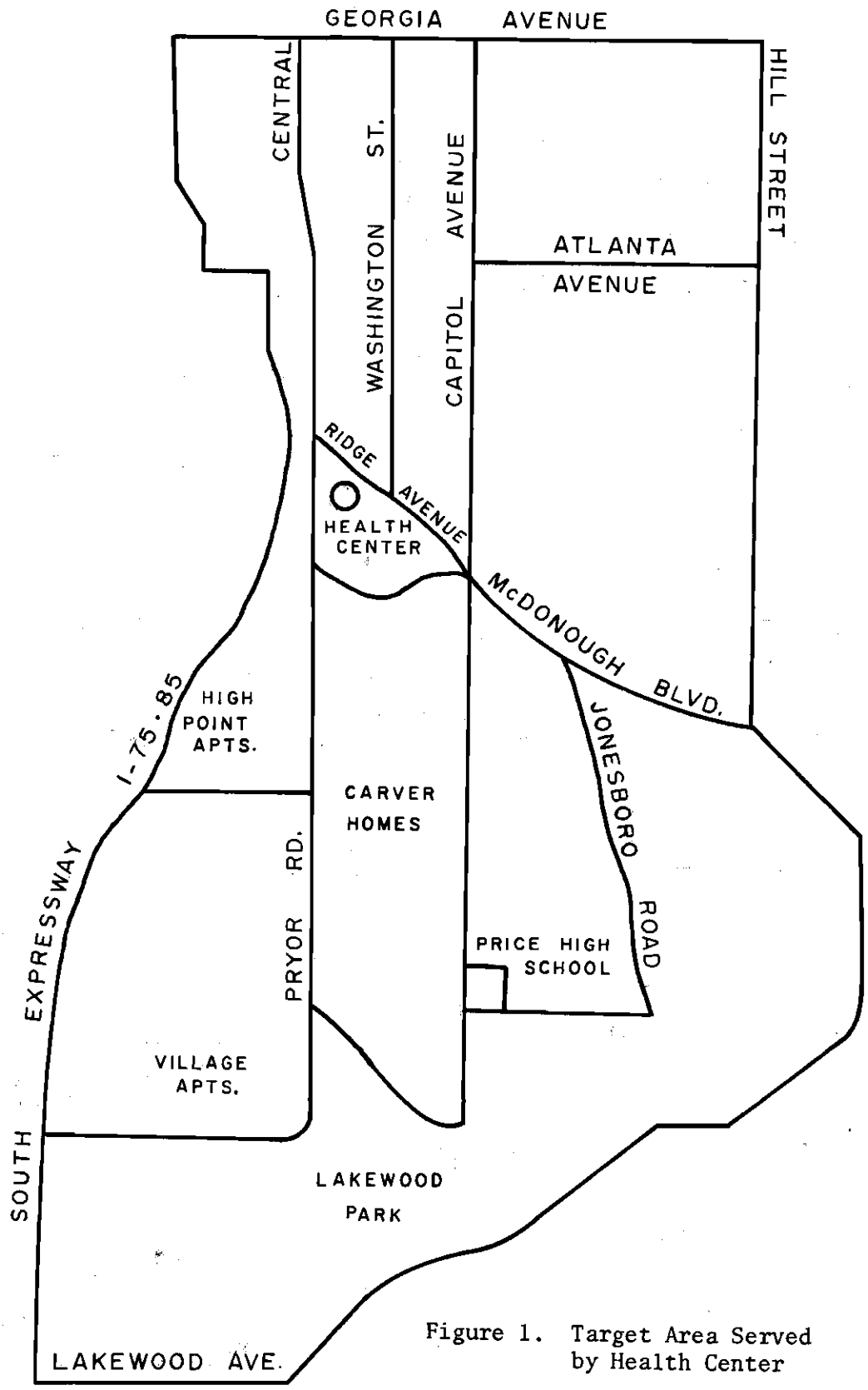

Figure 1. Target Area Served by Health Center

initiated in 1967, opened at a temporary location in July, 1968 and moved into its present facility in April, 1969. It is a typical OEO neighborhood health center offering comprehensive health services. (Originally called the Price Area Health Center, the name was changed to the Atlanta Southside Comprehensive Health Center because of the negative identification of residents with the Price Neighborhood Service Center operated by Economic Opportunity Atlanta.)

Background of the Center

In the fall of 1966, Senator Edward Kennedy of Massachusetts secured amendments to the Economic Opportunity Act of 1964, including $50 million for supporting additional health center projects. This appropriation resulted from the success of two demonstration health center projects in Boston (Columbia Point) and in Denver (the Eastside and Westside Health Centers). In response to this, Economic Opportunity Atlanta (EOA), the city's local community action agency, submitted an application for the development of a health center in a low-income neighborhood.

Initiation of the Project

OEO had established its policy of requiring that the sponsoring agency for any health center project would have to be a medical school, hospital, medical society, or other established organization. Charles Emmerich, the Executive Director of EOA, contacted Dean Arthur Richardson of the Emory University School of Medicine regarding the possibility of Emory sponsoring a health center project. Officials of the school were less than enthusiastic because of the reaction that most private physicians would have to ward such a program involving

governmental intervention in health care, and because it would involve the use of an educational institution in the actual practice of medicine.[127]

In early January, 1967, Mr. Emmerich called a meeting of several local health officials including representatives of Emory. One of those present, Dr. Thomas Sellers, Chairman of the Department of Preventive Medicine and Community Health at Emory, was requested to formulate a plan for a health center project to be included with the application and submitted by February 15. However, because no planning had been done, Emory rejected the invitation to participate in the project. There was insufficient time to carry out an adequate study and to formulate a suitable plan for such a project.[128]

The project proposal was attractive, however, and according to Dr. Sellers, "We did begin to think about it."[129] A report outlining a long-range plan for Emory in the early 1960's had recommended that the school become involved in outpatient clinics in low-income areas, and the EOA offer was just too great an opportunity to overlook. Emory told EOA that they would be willing to begin planning for the submission of an application for the next funding period. EOA replied that they had been assured that Atlanta could have the funds for a health center, but only if an application were filed for the current funding period. To wait a year would jeopardize their chances because of the increased competition for funds anticipated.[130]

EOA was granted an extension on the deadline from February 15 to March 15. Emory still hesitated, but late in February, 1967, the decision was made to participate in the project. Dr. Sellers and

Dr. William Marine wrote a preliminary proposal in two weeks and had to prepare a detailed proposal for submission in mid-April. Between February 20 and March 15, a target area had to be selected, a proposal written, and a preliminary budget developed. Several officials made a quick tour of health centers at Columbia Point in Boston, Montefiore in New York City, and the Watts center and returned to write the grant proposal.[131]

The joint proposal with the Fulton County Medical Society was signed March 13, 1967 requesting funding for a one-year period beginning June, 1967. The society was by no means completely in favor of a Federally funded comprehensive health facility of the type planned and it offered a counterproposal for the development of a clinic in the Vine City area of Atlanta which would be staffed by volunteer private physicians. This health access station would provide limited health services and would function primarily as a referral center for more specialized care elsewhere. The society had been operating such a "triage" facility in Vine City and sought Federal funding for the continuation of the project. The medical society hoped that both the comprehensive health center and the society proposal would be funded so that the two could be evaluated and their effectiveness compared. However, OEO decided to fund only the comprehensive health center project with the first-year grant totalling $2,191,911.[132]

Goals of the Project

The joint proposal submitted to OEO by Emory listed the following specific aims for the health center:

(1) To provide a system of health services to care for all the health needs of the community; i.e., comprehensive;
(2) To set, maintain, and improve standards of medical care; i.e., quality care;
(3) To provide most of these services as close to the community as possible; i.e., neighborhood;
(4) To establish the close rapport and personal identification between the patient, his family, and the health team so necessary for the rendering of preventive and follow-up services; i.e., continuous, personal, and family-centered;
(5) To interrelate existing and fragmented health care facilities to provide for the needs of the patient and to avoid duplication and overlapping of services; i.e., coordinated;
(6) To provide easy access and flow of patients from one facility to another within the total system; i.e., "one-door";
(7) To explore utilization of neighborhood citizens in many different roles within the health project so as to (a) provide employment and opportunity for careers in health related activities; (b) extend the effectiveness and efficiency of the professional members of the health team; and (c) provide entrē and insight into the community;
(8) To fit the health center to the needs of the community rather than have the community fit the center;
(9) To provide evaluation of the program so as to obtain information which may be applied usefully to other future centers in Atlanta or other similar areas; and
(10) To provide in-service training programs for each of the personnel categories involved in the health center operation.[133]

Selection of the Target Neighborhood

Because of time it was not possible to perform an in-depth study for determining the most appropriate neighborhood for the health center. The Price Neighborhood Service Area was selected on the recommendation of EOA, although there were a number of low-income areas. This area was chosen not because it had a demonstrated need greater than other neighborhoods, but because it had already established a community organization. This organization, the South Atlanta Coordinating Council, had earlier expressed a desire to EOA to take part in the development of a mental health facility. When the funds became available for a comprehensive health center project, the Price neighborhood was the logical choice of EOA.[134]

Organization of the Center

The proposal submitted with the application for funding presented a detailed discussion of the organization of the health center as shown in Figure 2.[135] This section describes the center's organization and services as presented in the original proposal. Any subsequent changes will be indicated.

The Emory University School of Medicine was to subcontract from the Fulton County Medical Society for the final responsibility and operation of the health center through its Department of Preventive Medicine and Community Health. The center is advised by the Neighborhood Policy Board and by the Agency Advisory Board which facilitates the formation of liaisons and activity coordination with other agencies.

The health center has four units: (1) Administrative, (2) Education, (3) Research and Evaluation, and (4) Family Health Care. The following is a summary of each unit as described in detail in the proposal.

1. Administrative Unit. This unit includes the Project Director, Medical Director, Nursing Director, Community Organizer, Special Administrative Assistant, Business Manager, and supporting personnel.

2. Education Unit. The unit consists of an Education Director with doctoral education, an Assistant Director, and four teachers for the non-professional educational program. It coordinates all teaching and on-the-job training activities for non-professional groups including medical, nursing, social work, nutrition, medical secretary, clerk-typist, neighborhood health aide, clinic aide, etc.

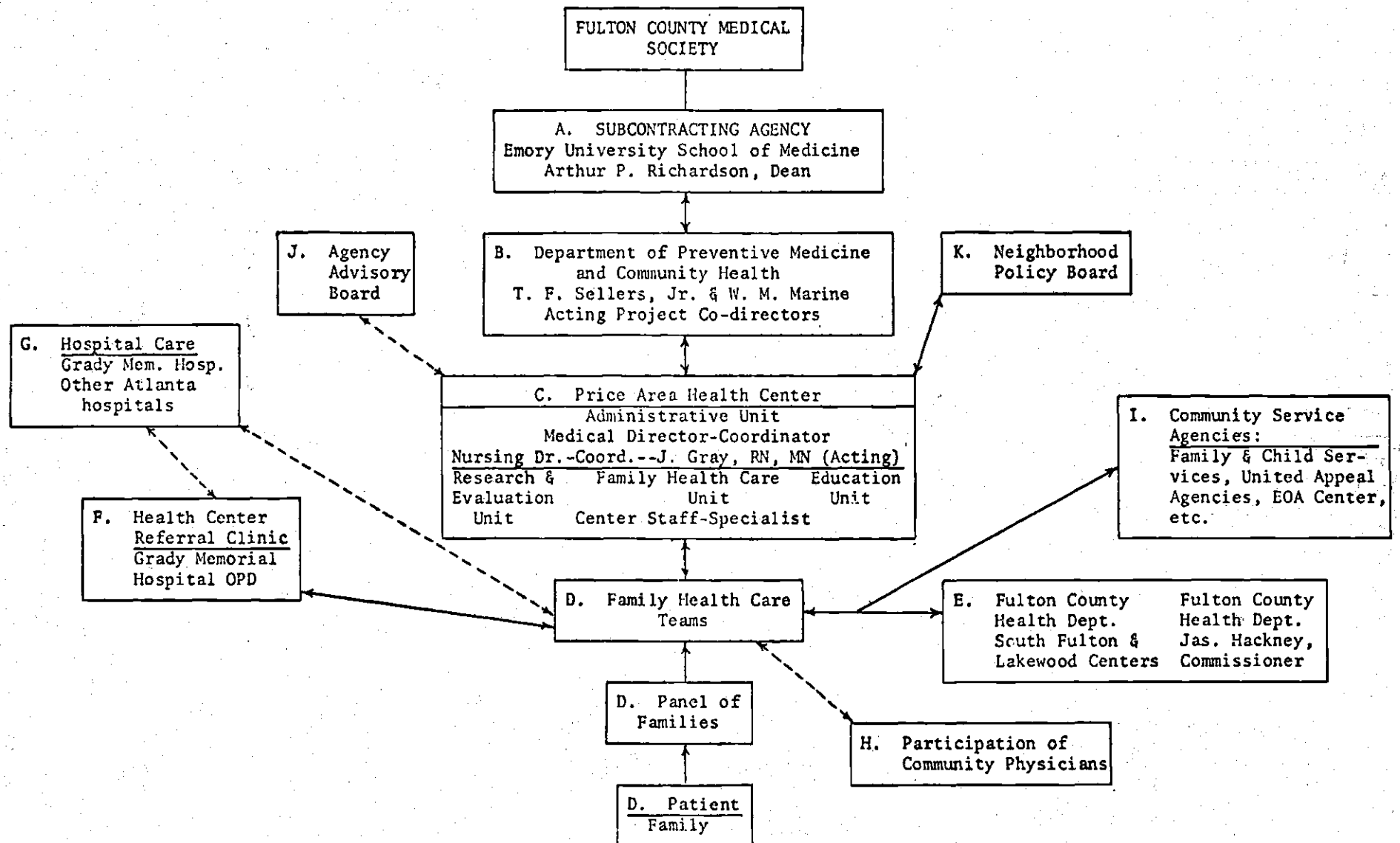

Figure 2. Table of Organization--Price Area Health Center

3. Research and Evaluation Unit. The unit is composed of a doctoral Director, a Psychologist or Sociological Assistant, a Research Assistant, a Cost-Benefit Analyst, a Programmer, and indigenous interviewers and supporting personnel. It establishes liaison with interested departments at Emory and elsewhere to encourage their participation in the development of the medical care research potential of the center.

4. Family Health Care Unit. This is the major service unit of the center and includes the Health Care Teams and a Panel of Families, Specialists, and the Health Center Staff.

(a) Health Care Teams and the Panel of Families. The health care team concept is designed to attack the special problems of indigent families. Six health care teams are planned (with four now functioning), each consisting of the following: one internist and one pediatrician (or two general practitioners) and four graduate nurses. The Nursing Group utilizes the team approach to family care emphasizing the physical, emotional, and social aspects of the patient as part of the comprehensive care program. Where possible, paraprofessionals under supervision are allowed to handle certain functions and responsibilities which allow the professional nurse to operate more efficiently. Each team is designed to have eight neighborhood health aides, one social worker, and supporting secretaries and clerk-typists. Each health team is assigned to a specific geographic area and treats only patients from that area. The panel of families is designed to serve as a feedback mechanism between the patients and the administration and health teams.

(b) Specialists. The following are directly available to the health care teams on a full-time basis: two psychiatrists, a public health nurse supervisor-consultant, pharmacists, an optometrist, a nutritionist, a podiatrist, and an occupational therapist. Part-time personnel include a gynecologist-obstetrician, a radiologist, and a lawyer. The center refers patients to specialists not available at the center. (The center now offers a complete range of specialized services which are available on a full-time basis.)

(c) Health Center Staff. The staff to support the center's service function include a unit manager, personnel manager, clinic nurses, interviewers, health center assistants, drivers, X-ray technicians, a medical records librarian, and security officers.

The health center also has special arrangements to cooperate with other health care providers and social agencies in the neighborhood and the city.

Fulton County Health Department. The health center target area is located within the area served by the South Fulton and Lakewood Health Centers of the Fulton County Health Department. The health department continues to provide public health nursing functions in the area. The activities of the Family Health Nursing Group are coordinated with those of the public health nurses to prevent overlap.

Health Center Referral Clinic. Space for a referral clinic is provided in the Grady Hospital outpatient department to assist patients coming to the hospital from the health center through special outpatient department evaluation and workup. This clinic also facilitates the rapid transfer of information about patients between the hospital and

the health center. The clinic staff includes a pediatrician and an internist (both part-time), two nurses, a junior administrator, and aides.

Hospital Care. An arrangement has been made whereby any patient may be referred and admitted to the hospital on the order of a health center physician. There are three ways in which a Grady eligible patient from the target area may be admitted to the hospital: (1) directly, (2) via the health center referral clinic located in the hospital, and (3) via other outpatient speciality clinics.

Participation of Community Physicians. The health center services are available to physicians of any patients in the area for referral. Patients not eligible for Grady service are referred to private physicians for fee-for-service care and hospital care at a private hospital. The participation of community physicians in the health center is encouraged.

Community Service Agencies. Close liaison with various official and voluntary agencies and organizations in the community is maintained to fulfill the goal of comprehensive care. The Agency Advisory Board advises the health center in this regard. This board includes a representative from each of the following: Atlanta Medical Association; Fulton County Medical Society (Medical Association of Atlanta); Emory University (not involved in the project directly); Fulton County Health Department; Community Council of Atlanta Area, Inc. (now defunct); Fulton County Department of Family and Children Services; Metropolitan Atlanta Mental Health Association: Division of Mental Health, Georgia Department of Public Health; Atlanta Hospital

Association; Georgia State Nurses Association, Fifth District; Greater Atlanta Local, Georgia State League for Nursing, Inc.; Grady Memorial Hospital; Visiting Nurses Association; Dental Association; Emory University Dental School; Division of Vocational Rehabilitation; Georgia State Department of Education; Georgia Pharmaceutical Association, and others as appropriate. Three members of the Neighborhood Policy Board also serve on the Agency Advisory Board.

Neighborhood Policy Board. This board is the principal vehicle for citizen participation in the health center. It has the responsibility to see that the staff implements policies of the center and that the center is responsive to community needs. Composed of fifteen members (initially appointed, later elected) from the community, the board participates in the following areas: developing methods of billing patients using center services, establishment of eligibility requirements corresponding to the poverty line index, recommendation of program emphases, approval of non-professional appointments and hiring policy and serving in an advisory capacity on professional appointments. The board has the right to appeal any decision of the center staff to EOA or OEO. (As discussed below, the board has been the focus of much controversy over the powers that it should have. Many of the members have pushed for more control over policy decisions while the center's administrators have tried to keep the board strictly advisory. However, Emory ended its participation in the project in September, 1973, and the board has since become incorporated and controls the policy decisions for the health center.)

Plans of Operation. The proposal for the health center

specified the following phases for program implementation: Phase I: The first six to twelve months are devoted to the recruitment of key personnel, securing and renovating a building, community organization, meetings with the city, county, and state officials and various officials of community agencies and collecting up-to-date demographic and health data.

Phase II: The second six months is an interim period continuing Phase I. The provision of some services begins as does full-scale non-professional training and teaching.

Phase III: During the second year, the center begins full-scale operation.

Neighborhood Involvement and Response

Emory faced problems from the start in organizing the health center. In May-June, 1967 Emory began holding several meetings with the residents in an effort to provide information about the center and to involve them in some of the planning going into it. Emory also attempted to establish a representative neighborhood board for the center.[136] However, EOA stepped in and said that the Health Committee of the Price Neighborhood Service Center (the local OEO-EOA community action group) would serve as the representative board. While Emory did not approve of this action, the school did not have the time or the opportunity to do anything about it. The Health Committee selected one representative from each of the ten sub-neighborhoods plus five professional people living or working in the area to serve on the Neighborhood Policy Board.[137]

Emory and the Neighborhood Policy Board were in conflict from

the start because they had different concepts about the health center. The principal disagreement was over whether the board would be advisory or policy making, a conflict which has plagued most of the health center projects. The situation was confused by the lack of direction from Washington, specifically the Office of Health Affairs of OEO. OEO told the neighborhood board that they were a policy-making body while Emory was told that the board was advisory. Then OEO told everyone that the board was policy making in some respects and advisory in others, but it never really defined these areas. (In 1969, the name of the board was changed to the Neighborhood Advisory Council in an effort to discourage the board from attempting to set policy in areas involving medical expertise.)[138]

OEO continually changed the ground rules under which Emory was to operate the center. But while OEO made the policy changes, "the onus of making these changes known to the community and implementing them always seemed to fall upon Emory."[139] For example, Emory received permission to pay board members for attendance at meetings. However, OEO changed this policy, and because Emory was the one to inform the board members, the school got the blame for having reneged on its promise.[140]

EOA was also the source of difficulties in regard to community organization. The agency became "politically vulnerable" within the community as a result of its involvement in the elections of members to the neighborhood board. It is difficult to know whether this was due to some defect in EOA or whether it is a defect in any governmental community action agency which is viewed as a controlling

mechanism that limits the absolute authority to the community group. At any rate, there were several individuals who emerged as "representatives" of the community and used neighborhood distrust of EOA and Emory to further their own political interests. (Elections were held to choose representatives on the board, but these elections were almost meaningless because they were not publicized and they involved only a small segment of the population.) There were four or five such leaders who were constantly antagonistic to the center of whom two or three served on the Neighborhood Policy Board.[141]

Emory was, of course, looked upon with suspicion because it had always been a totally white institution which was now involved in providing services to a largely black neighborhood. Consequently, every conflict was a potential racial issue. There was initially substantial opposition from the black physicians' group, the Atlanta Medical Association, although only one black physician practiced in the area and none lived there. Many of these black physicians had been refused admission to the Emory Medical School because of race, and they were understandably reluctant to welcome an Emory-sponsored facility which would intrude on their "turf" and possibly attract some of their patients.[142] (There was, however, no alliance between the neighborhood and the black physicians because the physicians were viewed with some distrust by the residents who felt that they were parasitic and overcharged for their services.)[143]

Perhaps one may wonder why the black physicians did not offer a counterproposal to OEO or why, if they were concerned about the quality of health care available to low-income blacks, they did not

provide such care. Black physicians certainly recognized the special needs of the poor and the differences in service provision that are required between the poor blacks and the middle-class blacks. The primary reason why they did not provide the services is that it was not economically feasible. Dr. Calvin Brown was the only physician practicing in the neighborhood. Often he treated residents for a nominal fee or at no cost, but he had too heavy a patient load to provide them with the special attention that they needed. It was difficult for a black physician to provide adequate care to the poor until the Medicare and Medicaid programs provided compensation.[144]

Even with improved compensation, however, it was obvious that many of the poor were not receiving adequate health care because they did not follow up on the care and treatment that they did receive. Why then did the black physicians not establish a clinic of some type to treat these "unreachables"? Although there is no known answer, there are several possible explanations. There seems to have been antagonism toward black physicians on the part of many neighborhood residents who felt that most black physicians overcharged the poor while providing second-rate services. In addition, an anti-organized medicine attitude on the part of OEO would have been a formidable obstacle. Consequently, there would not have been any value in the Atlanta Medical Association offering a health center proposal because the neighborhood would not have supported it and OEO would not have entertained it.[145]

The Atlanta Medical Association was opposed to the health center and filed protests (or threatened to) with OEO. Black physicians

were antagonistic because of Emory's involvement, but they also felt left out of the project. According to Dr. Brown, black physicians should have had much greater participation in the planning of the center but little effort was made to consult them.[146] This opposition was largely thwarted by the appointment of Dr. Brown as project co-director with Dr. William Marine in July, 1967. The former was reluctant to accept the position. He felt pressure from other black physicians who believed that he had "sold them out" to get a job with Emory. However, he realized that his position as the only physician serving the neighborhood obligated him to become involved in the center's development. Consequently, despite his reluctance, he agreed to become assistant director.[147]

Dr. Brown agreed to serve only if the director were black, but the black physician Emory wanted as director was disapproved by the black physicians who were opposed to any form of cooperation with the Emory-sponsored facility. Emory proceeded to appoint Dr. Marine as director, but because he was white, Dr. Brown demanded that they be made co-directors or he would refuse to serve at all. Emory acceded to his demands and the arrangement worked out well for the year the two were there. The only problem occurred in the summer of 1968 when Dr. Marine took a sabbatical leaving Dr. Brown to run the center. Dr. Brown demanded that the school appoint someone to substitute for Dr. Marine because he was not going to run the center by himself in the name of Emory. Emory again met his demand.[148]

With the help of Dean Arthur Richardson, Dr. Marine and Dr. Sellers, Dr. Brown also succeeded in having five black physicians

appointed to the staff at the medical school after dealing with the chairman of each department. (Acceptance of black students came later.) Consequently, after the first six or eight months of operation, much of the opposition of the black physicians had subsided because they were more interested in integrating Emory than in fighting the health center.[149]

There was obviously a mixed reaction from the community in the planning and development stages of the health center. As Robert Cleveland, a former administrator of the center put it, however, "The project suffered from a case of the 'antis'."[150] That is, almost everyone had an anti-health center and an anti-Emory attitude. There was little firm support for the project from any segment of the neighborhood. Emory was thrust into a rather hostile area with little preparation, few contacts among neighborhood residents, and with no experience in designing or operating health center projects.

One of the major problems encountered involved the training and hiring of neighborhood residents. One of the center's goals was to improve the socioeconomic status of residents through employment at the center, but this program often interfered with the smooth operation of the health center. The residents were understandably eager to land jobs, but those who did not were often antagonistic to the center. Many of the representatives on the Neighborhood Policy Board were offered jobs because if they were refused they would be able to harass the center from their positions on the board. Those who were hired were required to leave the board thus necessitating the training of replacements. Furthermore, the job training program

trained more people than the center needed and few of the excess could find better jobs outside the center. The administrators reacted to many problems by creating a new job position and training more people for it than were needed. The training and hiring programs were therefore a source of friction between the center and some community residents and a source of confusion within the center itself.[151]

The Planning Process for the Center

Time constraints prohibited detailed planning for the health center prior to submission of the funding application to OEO. The target neighborhood was selected by EOA with little or no study of its suitability. This section discusses the planning that was done for the health center both before and after the application was filed.

Determination of the Health Care Consumers

Economic Opportunity Atlanta selected the Price neighborhood as the site for the health center because it had expressed a desire for a health facility and because it had a certain level of community organization which was not available in other neighborhoods. Information about the target area and its residents was derived from the 1960 census and estimates made by the Atlanta Region Metropolitan Planning Commission (ARMPC).

Specific census tracts were chosen to correspond to the EOA Price neighborhood district so that census data could be used. However, there were some minor adjustments in the geographic boundaries of the area. One census tract ended at Atlanta Avenue on the north which is only two blocks south of Georgia Avenue, a major thoroughfare and a more suitable boundary. Consequently, the boundary was

shifted to Georgia Avenue. The other adjustments were minor in nature.

The area consisted of census tracts 55a, 55b, 56, and 57, accounting for 1.4 percent of Atlanta's total area. The total area population of 28,571 contained 7349 family groups or 4.4 percent of the city's population. The funding proposal included a variety of other information about the Price neighborhood and its population which is presented in Table 2.[152]

The most significant study of the neighborhood population came several months after the funding proposal had been submitted to OEO and the health center had begun operating. A 1968 survey of 1075 household residents conducted by the National Opinion Research Center of the University of Chicago was published in January, 1969. The survey gathered data regarding demographic and socioeconomic characteristics, eligibility for Medicare, Medicaid, and private health insurance, utilization of existing health services and health problems. While its accuracy and usefulness were to be later questioned (it greatly underestimated patient utilization of the health center), the findings were used as a basis for designing and operating the center's program.[153] The survey's general conclusions were as follows:

> Data indicate that the target population has more illness, and considerably lower utilization of health services, than the U.S. population as a whole, taking into account their respective age distributions. While this may be "explained" in some instances by other demographic characteristics, such as race, this does not alter the basic finding. Within the target population, there are surprisingly few differences between the poor, the near poor, and the remainder of the target population.[154]

Table 2. Population Characteristics of the Price Neighborhood

Race		Sex		Age	
White	24.4%	Male	46%	Under 20	50.2%
Non-white	75.6%	Female	54%	20-64	44.6%
				Over 64	5.2%

Population Density: Twenty-one and seven-tenths persons per acre (three times greater than city's 6.6 per acre).

Poverty Level: Seventy-five percent of the population (21,429) fall within the poverty index.

Unemployment: Unemployment rate twice that of the city.

Crime: Crime rate per 1000 residents is from 70 percent to 115 percent above that for the city as a whole with delinquency rates correspondingly high.

Drop-out Rate: High school rate is 35 percent above the rate citywide.

Mental Illness: Daily average of ninety-three residents of the area were on furlough from the state mental hospital in 1966.

Housing: Area contains 33 percent of the city's sub-standard housing, 10.2 percent of housing needing major repairs, and 6.8 percent of all delapidated housing.

Evaluation of the Existing Health Services and Health Needs

It was necessary to evaluate the health problems of the Price neighborhood population and the existing health care service system to determine the needs of the area. As mentioned, the best method to use in such a study is to consult the health care providers who have served the neighborhood. The Fulton County Health Department provided the following information which was included in the funding proposal:

> --total births in the area are 34.2 per 1000 general population as opposed to 23.2 per 1000 for Fulton County;
> --premature births are 3.5 per 1000 population compared to 1.9 per 1000 in Fulton County;
> --the infant mortality rate is 41.5 per 1000 live births in the Price neighborhood and 28 per 1000 in the Atlanta area;
> --total death rate is 14.8 per 1000 in the Price area and 10 per 1000 in Fulton County;
> --the rate of active tuberculosis cases is 156 percent greater in the Price area than for Fulton County and
> --communicable disease, excluding tuberculosis and venereal disease, is 3.9 per 1000 in the target area and 1.6 in the county; venereal disease infections have an incidence 40 percent greater than the average rate for the county.[155]

Discussions with private physicians, public health nurses, and other health care providers determined that the most common health problems in the area were those found in most low-income, predominantly black neighborhoods: hypertension, diabetes, obesity, alcoholism, and, most importantly, anxiety. The prevalence of anxiety provides evidence that the pressures of daily life take a heavy toll on the mental status of many low-income citizens. This anxiety can often lead to or aggravate physical illnesses.[156] Consequently, in treating such a population, "The physician should be as much a psychiatrist as a physician."[157] This points up the need for an adequate mental health component in the comprehensive care program offered by the health center.

An effort was made to evaluate the health resources available to the target population. As mentioned, Dr. Calvin Brown was the only private physician serving the neighborhood, and he is located on its western boundary. The South Fulton and Lakewood Health Centers of the Fulton County Health Department are also located within the target area but offer only traditional public health services such as TB and VD case-finding and follow-up and well-baby care.

For the majority of the residents, the primary source of both inpatient and outpatient care was Grady Memorial Hospital. As is the case with many large public hospitals serving substantial numbers of low-income people, the services at Grady, while generally of adequate quality, are inconvenient because of crowding, long waits, and impersonal care. The hospital is also inaccessible because of its distance from the neighborhood. These factors precluded many neighborhood residents from even seeking health care until it was absolutely necessary. A study of the area conducted by the Emory University Center for Research in Social Change revealed that the most frequently used health services at Grady were those involving childbirth and family planning followed by emergency medical and surgical care and psychiatric care.[158]

The survey conducted by the National Opinion Research Center was used to identify sources of health care available to the target population through an examination of data regarding physician visits, hospital admissions, and related information. While the results will not be detailed here, the general finding was that "slightly over 62 percent of the population use a hospital clinic or emergency room as

the usual source of care, while 30.5 percent have a private doctor. . . . 63 percent report having seen a physician within the twelve-month period preceding the interview."[159]

Site Selection

The grant proposal submitted by Emory recommended the location of the health center on the site of the former campus of the Gammon Theological Seminary situated in the central area of the Price neighborhood. The campus contains several structures formerly used as a dormitory, a dining hall, and an administration building. The dormitory was found to be in a condition suitable for renovation despite being over eighty years old. The proposal called for the dormitory to be used for patient care activities, the dining hall for administrative purposes, and the administration building for training activities. A library could be used for further expansion. The site was also located at the confluence of four major thoroughfares and adjacent to Carver Homes, the largest public housing development in the area. Also located in the campus area were the South Fulton Health Center, the Carver Vocational School, and the Bethlehem Community Center of the Methodist Church.[160]

The proposed site at Gammon Seminary appeared to be an excellent one. One particular advantage was that the OEO requirement calling for the renovation of buildings rather than the construction of new ones (a requirement which had caused problems for other centers) could be met by the use of buildings on the campus. However, a lack of communication and an administrative mix-up disrupted these plans and prevented the use of the proposed site. The president of the

seminary wrote a letter of intent informing Emory of his approval of its plans to use the seminary buildings for the health center. However, the president resigned at the next Board of Trustees meeting. Consequently, the letter of intent was not brought before the Board for its approval. Emory was not informed of this and the site was subsequently leased for other purposes without the school's knowledge.[161]

There was some problem in finding another site for the health center. Temporary headquarters were established in a small commercial building at 1070 Washington Street in December, 1967. This structure contained the center's offices and meeting rooms. A small clinic was set up in a church across the street at 1069 Washington and initial health services were begun in the spring of 1968. The entire structure was used by the health center including the sanctuary which was used as a meeting room. Even after a permanent location was established, the church continued to be used for mental health and educational programs.[162]

The search continued for a permanent site. Finally, some members of the community suggested two possibilities. One was an abandoned theater on Jonesboro Road which was rejected because it was in poor condition and too small. The second site, and the one selected as the permanent location, is at 1039 Ridge Avenue around the corner from the temporary facilities on Washington Street. The structure was a warehouse with 42,000 square feet of floor space formerly occupied by the Fulton Metal Bed Company. It was larger than necessary for the health center, but Emory decided that it was the most suitable facility. There were not many possible sites in

the neighborhood; in fact, Emory was "desperate" to find a site.[163] Ridge Avenue was selected not because it was such an excellent location but because there were no other feasible sites. OEO approved the site and the lease and agreed to provide the renovation funds.

The Ridge Avenue location is a good one from a transportation and accessibility standpoint. It is on bus lines and near population concentrations in public housing projects. It is in a visible location well known to neighborhood residents. The principal drawbacks to the site are some of the adjacent land uses. Immediately to the rear of the site is the Southern Railway line. To the west is a tire recapping plant and on the east a truck body conversion shop. Also in the area is an abandoned drive-in restaurant, an abandoned service station, a liquor store, junkyards, and vacant lots.[164]

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

This thesis has presented a discussion of neighborhood comprehensive health centers and has described the planning and development process for one such center, the Atlanta Southside Comprehensive Health Center. This chapter presents a series of conclusions about the ASCHC and offers some recommendations concerning the planning and development of future health centers.

Conclusions

Introduction

Although drawing general conclusions about the Atlanta Southside Comprehensive Health Center is difficult, it is fair to state that the center has been successful insofar as it has improved the health care services available to the neighborhood. The planning done for the center was not entirely adequate but was sufficient to assure that the target neighborhood would be served well. The center is in a good location and offers a wide range of services in a personal and continuous manner. There are undoubtedly many residents who still are not receiving medical attention, and special programs may be necessary to serve them. Moreover, the center has been afflicted with some political problems in its relations with community representatives which may have interfered with effective communication between the administration and neighborhood residents. Those individuals

interviewed during the research phase of this thesis had widely differing opinions on various aspects of the center's planning, development, and operation. One point on which they all agree, however, is that the center has been an asset to the neighborhood because of its success in providing health care services in a convenient and personal manner. The remainder of this section discusses more specific conclusions.

Planning the Center

1. There was sufficient physical planning for the health center. The Gammon Seminary site proposed in the funding application was an excellent one but an administrative problem precluded its use. The planners undertook a thorough study of alternative sites in an effort to find the most suitable one. Transportation and access factors were emphasized. The Ridge Avenue location was about the only one available, but it satisfied the requirements of the planners.

2. There was inadequate evaluation of the target area population. The health center began operations with an inaccurate view of the health care consumers or the target population it was designed to serve. The census data and other population statistics the planners accumulated were not sufficient to obtain a thorough understanding of the target population. The National Opinion Research Center survey was of little value and in fact misled the planners and operators of the health center. Several officials interviewed strongly criticized the survey and the accuracy of its results. Although the planners did not rely too heavily on the results of the survey, the results did cause them to underestimate the initial patient demand for center services. This lack of understanding of the characteristics and health needs of

the target population precluded the center from offering the type and scope of services needed. After a "shakedown" period of operation, the center could gauge the demands and adjust the services accordingly. More adequate planning and analysis of the target population and its health needs would have allowed the center to more adequately serve the community from the start. Perhaps one way to avoid such inaccurate results is to employ a local survey organization familiar with the neighborhood rather than one from another city.

3. There was an inadequate level of genuine citizen participation and involvement in the planning and development of the health center. The model of a comprehensive health center calls for the participation of the neighborhood residents in the planning and development of the center. In the case of ASCHC, however, there was little participation by rank-and-file citizens. The Neighborhood Policy Board was designed to represent the residents. However, several of the representatives were interested only in furthering their own political interests rather than effectively presenting the viewpoints and needs of their constituents. Consequently, there was antagonism toward the center and its administrators for the sake of furthering personal interests and power. (Some elections which were held to select board representatives were of questionable value because they were not publicized in the neighborhood.) There was also a lack of direction from OEO as to the powers and responsibilities of the neighborhood representatives and the board which left too much room for debate and controversy. The self-serving representatives disrupted the smooth operation of the center and created unwarranted

dissent and discord which at times has interfered with the center fulfilling its role as a health care delivery mechanism. Effective citizen participation and feedback is essential to the operation of the health center, but in the case of ASCHC, there was little of either.

The Effectiveness of the Center

1. The health center is accessible to the neighborhood residents. Despite the fact that the health center was not located on the site originally selected, the Ridge Avenue location is accessible to the neighborhood residents. It is roughly in the center of the neighborhood convenient to many residential areas and population concentrations. When the center began operations, the bus service was not entirely adequate. However, bus lines on Pryor Road and Ridge Avenues serve the neighborhood well, particularly the public housing projects to the south such as Carver Homes and Village Apartments. The center's transportation system serves those unable to reach the center by other means. A 1973 survey (the only attitudinal survey conducted to date) also showed that almost 80 percent of those questioned had no trouble reaching the center, about 10 percent had slight difficulty, while 10 percent had considerable difficulty. Although there may be room for improvement, the survey indicates that the patients feel that the center is convenient and accessible and is a welcome change from the remoteness of Grady Hospital. The officials interviewed also expressed the opinion that the center has attained its goal of providing accessible health care services in accordance with the neighborhood comprehensive health center model.

2. The center offers a complete range of services in

accordance with the concept of the neighborhood comprehensive health center model. There was a lag in the early development of the center during which the services offered were limited. This was due to the lack of a suitable facility and difficulty in attracting professional staff members. This lag was temporary, however, and within a few months the center offered a full range of services in accordance with the health center model described in Chapter IV. The center currently offers all health services including a complete array of specialized services.

3. The health services are personal, continuous, and non-fragmented. The health team concept used at the health center has apparently functioned well in providing services in a personal and efficient manner. Several of those interviewed had differing views as to the exact structure and chain of command which works best (specifically as to whether a physician should be team leader). However, they all expressed the opinion that the teams have achieved the goals established in the comprehensive care model. The 1973 attitudinal survey revealed that 54 percent of the patients questioned consider that the staff members always take a personal interest in them and 24 percent stated that they usually do. About 22 percent stated that the staff members sometimes take a personal interest while no one believed that personal care was unusual. In addition, nearly 88 percent believed that they always or usually received the care and advice that they thought they should.

4. There should be changes in the employment and job training services offered by the center. The health center model recommends

the training and employment of indigenous neighborhood residents for positions at the health center. This is part of the role that the center should play as a tool for social change as well as a health care delivery mechanism. However, there may have been too much emphasis on this aspect of the center's operation. Many of the board representatives, for example, were anxious to obtain positions at the center and were required to leave the board as soon as they were hired. In fact, the center was almost forced to hire them, because if it did not, the individuals would be in a position to harass the center from their positions on the board. In addition, other neighborhood residents were interested in landing jobs with the center. In short, to many residents the health center was viewed as a source of job training and employment rather than as a source of health care. Many of the residents viewed the center purely as a means to obtaining jobs. Certainly this is understandable, and if efficiently handled, such employment programs can be of great benefit. But when there is too much emphasis on jobs and training, the center's role as a health care delivery mechanism suffers. ASCHC was perhaps too closely involved with job training, a task which might be better handled if administered separately by a vocational school. Hiring practices should be administered in such a way that those refused employment will not harbor resentment against the health center.

Recommendations

1. In planning a health center, the most important factor is to cultivate an amiable or stable relationship with the target

neighborhood and its representatives which will allow cooperation and discourage conflict. This aspect of the planning process will have greater impact on the successful operation of the health center than will any other. It has been the experience of the health centers throughout the nation that community acceptance is essential. The conflict between the administration and the community representatives on the neighborhood board of the ASCHC was the result of inadequate preparation of the target population to become involved in the planning, development, and operation of the health center. This lack of preparation resulted from the rapidity with which the health center was conceived and formulated to meet the deadline for submission of the funding application. Such cases will be unusual. Most health center developers should have sufficient time to foster good community relations, and the following programs are recommended to achieve such a goal: (a) the appointment of an information specialist responsible for public relations to inform the community about the center and monitor its response; (b) a health planner and interviewers to conduct detailed studies of the target population and its health care needs; (c) education of the residents about the center beginning several months before it opens through advertising and programs in schools and existing community centers.

2. The role of the neighborhood board and the community representatives should be almost entirely advisory. There should be a well-defined mechanism for feedback from the residents to the administration through the representatives on the board. The residents should have input from the earliest stages of planning and

development of the center. The board, however, should not control the center and should not have the final decision over such matters as hiring and firing or the services provided by the center. These tasks should be left to the center's professional administration. A center operated by a board with neighborhood representatives can too often become nothing more than a platform for personal political activity which interferes with the center's primary function as a health care delivery mechanism. The citizen participation goal stated in the neighborhood health center concept does not imply community control of the center. The health center should not be a medium which the neighborhood uses to significantly increase its political influence or power city-wide.

3. Lines of authority within the health center should be clearly drawn to avoid unnecessary conflict and political infighting. The majority of the health center projects have been plagued by conflict between the administrators and community representatives. This conflict has been due largely to the lack of direction from OEO. Their guidelines have been vague and have left too much leeway for debate over organizational structure at the local level and within the health center and community. In all future projects, lines of authority and power should be established long before the center opens. (HEW is now responsible for health center projects and is apparently more strict in its control of the projects and their operating procedures.)

4. More research should be conducted concerning the most useful socioeconomic and health factors to be used in designing health center services. There are few standards or guidelines to follow in

the analysis of a target population and in the formulation of the health center's programs and services. Such standards were to have been one of the benefits of the research and evaluation programs of the recent health center projects. Apparently the centers have been so involved with daily operation that they have not stressed the development of such standards. The lack of standards necessitates the use of a "seat of the pants" method of designing services after the center opens and community demands are more accurately gauged. Obviously, incremental changes in the type and scope of services are useful and necessary. In many health center projects, however, there has been too much reliance on such an incremental method. More detailed planning and analysis of the population and its needs will enable the center to offer the necessary services sooner and thereby serve the community more effectively.

5. The health center should not undertake responsibilities or programs which will interfere with or restrict its function as a health care delivery mechanism. The neighborhood comprehensive health center is an instrument of social change, but its primary goal should be the delivery of health care services. No program should supercede or interfere with the goal of delivering health care. For example, job training and placement should be kept on a small scale if administered by the health center. If an ambitious program is to be established, it should be operated independently of the health center. Otherwise, the administration of the two may come into conflict and the efficiency and effectiveness of each may be adversely affected.

6. Several social agencies offering a variety of services

should be located within or near the health center. Social and welfare agencies have traditionally been scattered and inconvenient to the poor. The health center should serve as a one-stop center for neighborhood residents by offering all of the social services required by the residents including legal aid, welfare, social security, etc., and possibly an ombudsman or little city hall. If such a neighborhood multi-purpose center already exists, a new health center should be located nearby.

7. Health planners should place more emphasis on the problems of specific populations rather than on broad, area-wide plans. Health planning has traditionally been within the purview of health professionals such as physicians and health administrators. These professionals have been primarily concerned with short-term programs and goals with little emphasis on locational criteria or the populations being served. With the increased concern about metropolitan government and coordination, there has been more emphasis on the regional planning of health facilities, particularly with regard to hospitals. This has been necessary to overcome the complex interagency and interjurisdictional problems in metropolitan areas and to coordinate the growing interrelationships between the federal, state, and local governments.

The emphasis on regional planning of health facilities has been overdue. However, this regional emphasis has overlooked the importance of local or decentralized delivery mechanisms. Most of the regional health plans of recent years have been general and have tended to avoid locational issues. Rarely have they specified locations for

facilities. The plans have tended to stress the problems of an entire area rather than dealing with the specific problems of sub-area populations. This approach is the result of a system which has emphasized general hospitals and specialized facilities as the bases for health care delivery. There should be less emphasis on area-wide plans and more on those dealing with the health problems and needs of specific sub-area populations, particularly those in low-income, inner-city areas.

8. Urban planning has a vital role to play in health planning at the regional level and at the neighborhood level. The general nature of the regional health plans may be largely the result of the predominance of health professionals and administrators in the plan formation. Their preoccupation with health statistics should be balanced by inputs from urban planners who have a better understanding of physical and social planning considerations. This will allow more emphasis on detailed planning of health facilities and community-based service delivery. Perhaps urban planners can be of greatest value as suppliers of information concerning community development patterns, population trends, housing conditions, and various socio-economic data. This would facilitate consideration of site selection and transportation factors which health planners might overlook or be reluctant to analyze. These data could help the health planners anticipate changes in service areas which would affect service delivery. In addition, urban planners could apply some of their methodological skills in collecting and analyzing data, goal formulation, and the identification and evaluation of alternatives. Urban

planners can also supply information and guidance concerning relevant political factors which would influence health projects. Conversely, the urban planner could benefit from information from the health planner concerning the locational requirements of health facilities so that they can be taken into account in land use planning, urban renewal, and zoning. Information on health and disease from the health planners could also aid the urban planner in the formulation of housing and sanitation codes and inspection programs.

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