

## BACKGROUND, CONTEXT AND SIGNIFICANT ISSUES IN NEIGHBORHOOD HEALTH CENTER PROGRAMS

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When the War on Poverty began, health was not looked upon as one of its major battlefronts. How it came to be just that can be better understood by a look back into the atmosphere in which the early decisions were made.

The passage of the Economic Opportunity Act of 1964, mobilized—in Washington, D. C., and in communities large and small around the nation—a group of dedicated and exuberant men and women from highly diverse backgrounds, who were determined to make real the promise of the new antipoverty legislation. They were young—not necessarily in age, but they had the youth that Senator Robert Kennedy described so eloquently as “not a time of life, but a state of mind, a temper of the will, a quality of imagination, a predominance of courage over timidity, of the appetite for adventure over the love of ease.” They were there to implement a piece of legislation that provided an unprecedented opportunity for the federal government to support the development of new ways of dealing with old problems.

In the headquarters of the Community Action Program, we had the task of seeking out and defining some of the ways by which the federal government could most effectively assist local communities in their efforts to eradicate poverty. At the beginning, the number of fronts on which the war on poverty could be waged seemed to be

unlimited. The question that occupied us was how could we assure that the money for which we were in some measure responsible would be spent in ways that were to make a real difference, both in the quality of everyday life of individual poor people in this nation, as well as for the future of poverty as a brutal fact of life in America?

The question of health first arose quite incidentally, as communities found that job training for a worker who would be ultimately refused employment because of a physical disability made no sense, that educational improvements meant nothing to children whose physical impairments made learning impossible and that lack of prenatal care could cause harm that no later intervention could reverse.

Proposals came in from around the country, requesting funds to purchase certain categories of health care and services that had been most notably inadequate for the poor. Simultaneously, task forces in other governmental agencies were encouraging the Office of Economic Opportunity (OEO) to act in the field of health by making funds available to plug specific loopholes in existing publicly supported services. Such efforts were undertaken in a large number of communities, with general, unearmarked community action funds.

While this was being done, however, several very practical demonstrations indicated that the basic institutional arrangements—governmental and private—whereby health services were made available to the poor were defective, and that to the extent that health services were relevant to health status, the health of the poor could not be improved without fundamental changes in the arrangements whereby health services were organized and delivered. We were thus highly receptive to the advice from consultants that we should devote at least some research and demonstration funds to projects which would deal with the fundamental problem of the organization of medical care. We then entered enthusiastically into preliminary discussions with individuals whose own studies and experience had led them to similar conclusions and who were thinking of undertaking programs with this end in view.

All analysis of the obstacles that prevented poor people from obtaining the best possible health services that American medicine

was capable of providing made apparent that any attempt to deal with fundamental problems must be fairly comprehensive, and would, therefore, be immensely complicated and very expensive. Probably the most difficult and significant decision in the health area made by OEO during its first year of operation was to support programs that were addressed to the fundamental problems, despite the cost and complexity of such programs. A second significant decision was a corollary of the first: that to the fullest extent possible OEO funds would not be used to replace others, but instead would be used to encourage arrangements whereby other funds and services would be integrated as part of one cohesive whole. (Interagency efforts to make this principle a reality have been constantly and strenuously pursued—with frequently slow, but sometimes striking, success—since August, 1965.)

Further discussions, which took place among the staff, with a growing number of thoughtful and wise consultants and with an enormously impressive group of potential project sponsors, produced the basic outlines of a new institutional form for the rendering of medical care, which has since become known as the neighborhood health center.

The basic characteristics of the neighborhood health center were envisaged as follows:

1. Focus on the needs of the poor.
2. A one-door facility, readily accessible in terms of time and place, in which virtually all ambulatory health services are made available.
3. Intensive participation by and involvement of the population to be served, both in policy making and as employees.
4. Full integration of and with existing sources of services and funds.
5. Assurance of personalized, high-quality care, and professional staff of the highest caliber.
6. Close coordination with other community resources.
7. Sponsorship by a wide variety of public and private auspices.

Three grants were made by OEO in 1965 for programs designed

to incorporate these elements, and, by early 1966, the problems with which these programs were attempting to deal came increasingly to public attention. Alonzo S. Yerby, after describing to the White House Conference on Health the circumstances under which poor people received medical care, called for a national commitment to assure that all Americans, regardless of income, will have "equal access to health services as good as we can make them, and that the poor will no longer be forced to barter their dignity for their health." At the same time, the implementation of both the Medicare and Medicaid legislation provided additional evidence of the difficulties encountered by programs that furnished only money to pay for services and did not afford the opportunity to encourage improved institutional arrangements for providing those services.

In that context, and at that time, therefore, it was not surprising that an immediate response was received from physicians, hospitals, medical schools and health departments who saw in the research and demonstration program the possibility of support for something that had long been urgently needed, and for which federal support in sufficiently flexible form had not earlier been available. (The fact that the early constituency of the neighborhood health center program consisted, by and large, of the providers and not the consumers of service was later to lead to difficulty. We did not fully appreciate that the requirement of full participation by those being served after a proposal had been approved could never make up for the fact that the project had been originated and formulated by the professionals alone.)

By the summer of 1966, eight demonstration neighborhood health center programs had been approved, among them the project that is the subject of the following articles. Enough experience had been amassed to lead Senator Robert F. Kennedy to formulate an amendment to the Economic Opportunity Act to set aside special funds to support the "development and implementation of comprehensive health services programs focused upon the needs of persons residing in urban or rural areas having high concentrations of poverty and a marked inadequacy of health services." Congress appropriated 50 million dollars for this purpose in 1967, and during that

year an additional 33 neighborhood health center projects were approved. As of June, 1968, 30 projects are in operation, and 44 more have been approved. The Montefiore Medical Care Demonstration described in the following pages is an excellent illustration of these programs, although it is perhaps not typical, since the enormous diversity among the projects makes impossible the selection of one as "typical."

When all the programs that have been funded to date are fully operational, they will serve nearly one million people and will make available 2,000 jobs for persons living in the neighborhoods served. The currently funded projects utilize 700 physicians on a full- or part-time basis, and involve one-quarter of the nation's medical schools—with another one-quarter indicating intent to participate.

Each of these projects is struggling, in its own way, with issues to which each must develop its own response, reflecting the widely diverse circumstances in which each project has been designed and is operating. Some of these issues are:

1. The development of totally new relationships between the consumers and providers of service, where professionals take responsibility for the professional aspects of the operation, while the new institution (be it a neighborhood health center or other institutional arrangement created to accomplish a similar purpose) becomes truly responsive to and under the control of the people it serves.
2. The development of new kinds of health roles and careers making possible a more effective delivery of services, and methods of training and utilizing new sources of manpower therefor.
3. The extent to which the organization of a neighborhood around one kind of need (health services) can form the basis for successful community action in other substantive areas (e.g., welfare, housing, education).
4. The extent to which an institution created to serve one function (the neighborhood health center) can and should become the physical and organizational focus of other kinds of anti-poverty activities (e.g., legal services, day care).

5. The modification and refinement of institutional and organizational arrangements to assure personalized care, family oriented care, care that will conform to high-quality standards, and be attractive to professional personnel of high caliber.

On the basis of the experience now being accumulated around the country in the 44 different programs, each individual project will become better equipped to fulfill its mission as it evolves its answers to such issues as the above. It should also be possible to shed light on additional questions that must be better answered than they have been in the past, if this nation is going to meet the health needs of all Americans more effectively. For example:

How can the medical care job be divided up in new and better ways, among new kinds of professionals and nonprofessionals, while assuring both quality and acceptability? What kind of education and training is required, and what kinds of institutions are best suited to provide such training?

Will the training and utilization of neighborhood people in ancillary health roles provide the pathway for them or their children into medical, dental, or nursing schools as well?

How many diverse kinds of organizational frameworks can be developed that make possible comprehensiveness and coherence of services, personalized care, the supervision of quality and the opportunity for resident participation?

How can federal agencies be encouraged to work together even when it means giving up a degree of sovereignty here and there, to enable a community institution to deliver a comprehensive package of services that are supported from a variety of sources?

How can the needs of consumers of service for care of high quality, rendered in a setting that is accessible and acceptable to them, be made compatible with a health industry based in large part on individual enterprise, competition and profits? In what circumstances will the public support some supervision over the activities of health professionals?

What is “mainstream” medical care? Do some parts of the medical care system, such as the entry point to the system and the locus of day-to-day (primary) care, require greater adaptation to the needs of various segments of the community (such as the poor) than do the more sophisticated parts of the system, such as hospitals?

Can neighborhood health centers and similar programs be expected to stand in splendid isolation and stark contrast to the more traditional ways of rendering health services in metropolitan areas, or will they begin to tug the rest of the system in their wake?

Can poor people exercise control over institutions that they share with the middle class? Does the inclusion of middle-class persons in the constituency of a service institution increase the chances of its providing high-quality services? How necessary is a degree of control on the part of those being served? What forms of control over what issues are acceptable to the consumers, to the providers? How can the positions of the two groups be brought closer together? What is the future of the nonprofit community health corporation where providers and consumers of service function as peers in meeting the community's needs?

What is the relative importance to the achievement of high-quality care of consumer participation in policy-making and of the caliber of the sponsoring health or medical institution or agency?

What factors will influence maintenance of quality in the provision of services when the program is beyond the excitement and innovative spirit of its early developmental phases?

Regardless of what the answers to these questions will turn out to be, it is clear that the neighborhood health center program provides an excellent example of the kind of federal action that makes possible an effective and flexible response by an enormous variety of local institutions to a set of urgent and complex problems. Of course, important as that fact may be in relation to the future role

of the federal government in solving the most pressing social crises, one must go on to note that the aspirations of the thousands of people who are today intimately associated with the program in its many forms surely go further. If these aspirations are realized, the results can be measured in less suffering and enriched lives.