E000383

AREA
the V-minute news

VOL. I - NO. 27 November 6, 1969

THE LATEST FROM DRMP. . . . .

(The following summary was prepared by Dr. Herbert O. Mathewson who was Project Officer for five Summer Student Health Projects funded by RMP Service in 1968. It is reproduced baecause of its relevance to current health care activities in urban communities. It may suggest ways in which RMP can become more deeply involved in resolving problems of urban health. Copies of reports of each of the Student Projects are available from Publications Service, Office of Communications and Public Information, Regional Medical Programs Service, Wiscon Building, Room 308, 9000 Rockville Pike, Bethesda, Maryland 20014.)

During 1968, the Division of Regional Medical Programs supported five Student Health Projects (SHP) that placed nearly 400 health professions students in poverty communities throughout the U. S. for ten summer weeks. These medical, nursing, social work, dental, and law students worked and lived within urban and rural black, white, and brown (Spanish-American) communities in Metropolitan New York, Philadelphia, Chicago, Colorado, and Southern California.

The objectives of the Student Health Projects were to facilitate the provision of health services to these communities and to learn something about the realities of health problems in poverty communities, an opportunity not offered by the usual professional school curriculum. The students' daily experiences, their reactions to what they saw, and their reflections on what they experienced are described in detail in the five separate Student Project Reports available from the Division.

In the spring of 1968, the Division of Regional Medical Programs and some regions perceived particular difficulties in discharging their responsibilities for the improvement of patient care in rural and urban poverty communities. The planning of relevant health care programs and the establishment of appropriate "cooperative arrangements" were hampered, in part, by lack of information on the perceptions of and the attitudes toward health and health care programs held by the residents of these specific communities. It was readily obvious that such information could not be obtained through traditional channels (formal surveys). The Student Health Projects, having already developed the professional-community relationships prerequisite to such a task, were asked by the Division to utilize those relationships to develop information for their local RMP and for the Division which could assist the definition of:

1. New types of cooperative arrangements between professional and community organizations and individuals.

2. Urban community organization problems pertinent to RMP programs.

3. Present adequacy of health services in the community as perceived by the residents.

4. Health attitudes, and the response to health education; including the influence on both of social and cultural factors.

5. New types of health careers and roles, and the effect of health manpower recruitment efforts in disadvantaged urban areas.

6. Health status of the urban community in terms of heart disease, cancer, stroke, and any other diseases of major significance.

An equally if not more important objective of the Division's support of these SHP's was to increase the number and substance of contact between the organized poverty communities and the local RMP via the students' activities which sought to involve both groups.

Useful information in each of the six areas listed above is contained within the individual reports from the Student Health Projects. These reports contain so much information that summarization is difficult. The following pages try to highlight some of that useful information and briefly discuss some implications of it:

Cooperative Arrangements between Professional and Community Organizations:

The black-white confrontation was a dominant theme in nearly all the Projects. It affected the entire complexion of the Projects by complicating the already complex professional-consumer relationships. The SHP participants (more "liberal," less professionally-oriented than than student non-participants) were still perceived by the communities as professionals; i.e., motivated by narrow, professionally-oriented goals. Even the black student in the black community was sometimes hampered by these perceptions.

Perceived as professionals, the students themselves had difficulty defining the other side of the equation--the community. Community groups that appeared cohesive dissolved before their eyes and were replaced by others. Organizational jealousies, inertia, and overlapping constituencies characterize community organizations as they do professional organizations.

Despite these problems, the Projects did encourage the development of some new cooperative arrangements. Selected examples include:

- The first meeting between the New York Metropolitan RMP and Brooklyn Model Cities Agency staffs was arranged by New York SHP participants.
- The UCLA-RMP provided critical seed money for the establishment of a health clinic in Venice which had developed as the direct result of two years of SHP effort within that community.
- In Harlem, the Headstart Follow-up Student Project succeeded in obtaining continuing support by Columbia University for the training and utilization of resident health agents.
- In Newark, the students working with the developing Community Advisory Group to Martland Hospital also worked with the Newark RMP Urban Coordinator based in the Newark Model Cities Office.

These examples describe new cooperative arrangements between organized providers (RMP and others) and consumers. The individual SHP Reports describe in great detail new types of "cooperative arrangements" that are possible between individual providers and consumers.

A distinct message from each of the Projects is that the term "cooperative arrangements" is a poor one to describe the provider-consumer "Negotiation" (with its labor-management connotations) seems a more appropriate work. The students perceived that professionals were uncomfortable when meeting with organized community groups (black, brown, or white) as equal participants in a negotiation process. The students themselves were uncomfortable when involved in similar negotiation processes within their own Projects.

Urban Community Organization:

The students often worked with community organizations that were not primarily oriented to health problems in order to establish a credible base for their activities. It was clear that the communities were beset with an inseparable mix of social, economic, political, and health problems. At first glance, efforts to clean up a dirty public swimming pool seems to have little relation to the task of improving the delivery of health services. One need only recall that the total immersion of black skin in chlorinated water seemed only peripherally related to civil rights, but it became an effective issue in that struggle for equality.

There is no doubt that equal health rights is an issue. The community is less interested

in the content of care (the chlorine level of the swimming pool or the use of specific antibiotics) than in the setting of that care (accessibility, appropriateness, and affability).

The difficulties in defining the "community" and in sorting out the various constituencies has already been mentioned. It was the major problem in the urban areas and was often closely related to the black-white confrontation. The "community" is best described in terms of issues. The Projects leave no doubt that there are, in fact, significant "health communities" which are as well-organized and as clearly focussed as those "communities" seeking jobs and education reform. The existence and roles of these valuable community resources for improved health care are well described in the SHP Reports.

Community Perceptions of Health Care and Health Attitudes:

Much of this information in the Reports is anecdotal, but it could be extremely useful in gauging the local community's awareness of medical care needs and their view of established programs designed to meet those needs. A few surveys were done with appropriate sampling so that generalizations are possible in selected localities.

Not surprisingly, all Projects found an overwhelming perceived need for ambulatory care services that were convenient, competent, and courteous. This was true of urban and rural communities; white, black, or brown. The Chicago SHP Report documents how patients will travel farther (passing two other hospitals) to go to a third hospital outpatient clinic which they feel "accepts" them. This differential use of hospital ambulatory facilties by black patients has been suggested by other studies as well.

The community residents (both urban and rural) seemed surprisingly sophisticated (i.e., above students' expectations) about the use of health services. This was particularly true of urban mothers using hospital clinics for their children. It might be described as "utilization savvy," and it appeared in many different forms.

- In Colorado, a study of folk medicine practices among rural Spanish-Americans found that only about 25% of their care was received from folk medicine sources. It had been anticipated that over 50% of their care would be from these folk sources.

- In Chicago, a student study of chronic disease screening follow-up showed that the majority of patients with abnormal findings had been seen again by either a physician, within a city hospital clinic, or in a private hospital, and that many of these patients remained under appropriate treatment. This too was an unexpected finding since previous studies had not been able to examine all possible sources of follow-up care.

The Reports detail several case histories of apparent community apathy toward health problems. As in white, middle-class communities, it was sometimes difficult to get people out of their apartments and to a meeting to discuss what seemed to be important issues. The most obvious incidents of such apathy occurred where the students' objectives did not match the community's Lead poisoning, drug addiction, and welfare medical benefits were the issues of most concern to most urban communities. In Chicago, a solitary SHP participant organized literally scores of organizations around the issue of teenage drug abuse and won support from over twenty communities in Chicago for a program to combat it.

Health Careers and Manpower Recruitment:

Jobs are a top priority in proverty communities, and the expanding health industry in an increasingly service-oriented economy is looked to as a major source of employment. The black and the brown poverty communities seem to look in part to the health industry as a mechanism for upward mobility, as the Jews looked to the schools and the Irish and Italians looked to the trades.

Residents of these communities aspire to all types of health professional careers and roles. The family health worker, or the health agent, or the resident agent is a new role which was [illegible] by several of the Projects.

CALENDAR

STAFF MEETINGS ARE SUBJECT TO SUDDEN CHANGES--PLEASE CHECK WITH OFFICE FOR LATEST INFORMATION
ALL MEETINGS ARE IN CONFERENCE ROOM UNLESS OTHERWISE INDICATED

NOV.			
11	7:30 p.m.	AREA V Area Advisory Group Meeting	
12	9:30 a.m.	AREA V Staff Meeting	
12	10:00 a.m. to 5:00 p.m.	CCRMP Meeting	Thunderbolt Hotel San Francisco

- COMMITTEE CHAIRMEN'S MEETINGS -

November 21   December 5   December 19

- SPECIAL MEETINGS -

November 21 Conference on Community Health Resources - Sportsmen's Lodge
November 22 RMP-East Los Angeles Community Health Workshop (second session)

Most Projects brought high school students from the community into the activities in one way or another. The health science students acted as role models for these students, encouraged their questions about health careers, and offered experiences to them in various health facilities and programs.

Health Status:

Statistical surveying of the diseases prevalent within these communities was not an objective of these Projects; some of this information is available elsewhere. Most of the communities (with the notable exception of the American-Indian community in Chicago which asked the students to obtain for them desparately needed information on their health needs) felt that they were over-surveyed and under-serviced.

Most of the information on health status in the Reports is presented in anecdotal form. It is very useful in understanding the problems accompanying certain kinds of health status, rather than the actual health status itself; an important contribution.

Conclusions:

- The wealth of information contained within the Reports provides both raw data and where it has been analyzed by the students, some insights into health care problems at the point of delivery (the local neighborhood). It remains to be seen how this information will be used for local RMP project development.

- The interaction between local RMP's and organized community groups as a result of the students' activities was less than hoped for, but where it occurred, it had obvious beneficial effects.

What general statements can Regional Medical Programs derive from these Projects?

- Any program that seeks to have relevancy to the health service problems in poverty communities must respond to the demands (perceived needs) for ambulatory care, consumer influence, and program flexibility. Categorically funded activities are difficult to operate non-categorically at the delivery point, though that is what appears to be needed.

- Regional Medical Programs, as a provider-oriented program, should anticipate that it will be drawn increasingly into negotiations with consumer groups. Development of consumer [illegible] within RMP at the present time, will ease that negotiation process.