To provide health care for the ghetto poor, prospective patients can be reached if their particular cultural and economic aspects are taken into account. To do this the neighborhood is suggested as the appropriate unit for programing. In such areas "neighborhood representatives" have been found to be uniquely suited to involve the disadvantaged client.

INVOLVING THE URBAN POOR IN HEALTH SERVICES THROUGH ACCOMMODATION—THE EMPLOYMENT OF NEIGHBORHOOD REPRESENTATIVES

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PUBLIC health practitioners are concerned with the difficulties of providing health services to persons in poverty and ethnic subgroups residing in urban "medical ghettos."[a] Although the concept of multiple etiology of disease has been formulated for some time and some awareness of the value system differences between the middle-class professional and the disadvantaged patient has been gained, the latter is still referred to as "hard-to-reach."[1]

The position of this paper is that the culturally and socially disadvantaged patient is not "hard-to-reach" when programs accommodate his motivational orientation. This paper will consider the following concepts:

1. Patient accommodation as a means whereby the disadvantaged individual is recruited to health care.
2. The urban "neighborhood" as the basic unit for organizing health care programs.
3. The employment of indigenous workers to involve the disadvantaged patient in the accommodation process.

The Ghetto and Accommodation

In the urban medical ghetto there are prevalent feelings of "we" and "they." The ghetto member sees persons operating outside his life space[2] as "they," while his fellow members are designated as "we." In the wide field of social welfare, the ghetto member sees the ADC worker, the probation officer, and the public health professional as the unwanted "they" group. The ghetto member feels unable to influence the welfare programs promoted in his behalf.[1] Although dependent upon them, he resists involvement and remains dependent.

Ghetto members lead crisis-ridden lives. Dealing with these crises creates a value system that gives highest priority to satisfaction of immediate needs. In this system, disease is a concern only when it is an emergency. A value for preventive health care cannot arise in such an environment.

In view of these two factors—the resistance to involvement and the crisis orientation of the poor—health programs must include a component of social action that transcends the mere provision of medical care. Immediate problems demand immediate solutions. In this regard, accommodation of imme-

diate needs can become a vehicle for recruiting the disadvantaged client to health care. In this sense, a value for health develops as a latent consequence of a more general problem-solving process.

The Neighborhood[b]

In order to accommodate a patient group, the characteristics of that particular group must be identified and program methods tailored to specific needs. With this in mind, the disadvantaged urban neighborhood should be considered as the unit of public health programing. Because the neighborhood tends to be more homogeneous when contrasted to larger communities, programs can be designed to accomplish particular goals unique to the neighborhood.

Evidences of the existence of "neighborhoods" are as follows:

1. Large extended families within a specific area.
2. Isolation of specific areas by freeways, rivers, and industrial infiltration of residential areas.
3. Similar social and economic problems among residents of a given area.
4. An interaction pattern confined to a specific area.
5. Use of facilities, such as stores, close to their residences.
6. The isolation of ethnic groups (a form of ethnocentrism).[3]
7. An informal network of "caretakers"[4] both internal and external serving a residential area.

The actual development of technics, specific to a particular neighborhood group and conducive to the accommodation process, demands some significant departures from traditional public health practice. People cannot be helped if they cannot be reached. A wide variety of innovations must be considered. Among these are role changes of the professional staff and the addition of new members to the health task force.

Professionals have experienced difficulties in effectively communicating with, and ultimately involving, the disadvantaged client. Even the most thoughtful attempts by genuinely sensitive professionals to "go native" often go unrewarded.

Reiff and Reissman identify this problem and its potential solution.

> "Even professionals who have excellent relationship skills are limited by the nature of their function as an 'expert'. This definition of role, which they and the poor both hold, prevent the development of a fully-rounded everyday relationship. Yet it is this very type of relationship that is the key to effective program participation on the part of the poor. And it is the very type of relationship that the indigenous nonprofessional can establish. He 'belongs', he is a significant other; he is 'one of us'. He can be invited to weddings, parties, funerals, and other gatherings—and he can go."[5]

The Neighborhood Representative

Departing from the concept of the indigenous nonprofessional,[c] the Maternity and Infant Care Project,[d] administered by Denver's Department of Health and Hospitals, has created a new role for indigenous people. Neighborhood representatives, as they are called, are hired specifically to represent their disadvantaged neighborhood. In this regard, the neighborhood representative, as a semi-independent worker, becomes a "link" representing community life and values to the professionals and health programs to the low-income client. Unlike the nonprofessionals, representatives are not closely supervised nor are subprofessional tasks imposed upon them. Emphasis is placed on the development of their unique style and relationships with the population being served. The natural skills of the representatives enable them to interpret the nature and extent of health services in a manner appropriate to the subculture. Newly learned skills in terms of knowledge of other

social agencies, the services they offer, and methods of contact allow the neighborhood representative to solve other problems of a more immediate nature, which may act as barriers to the clients' use of health services. In this new role, the neighborhood representative can destroy the myth of the "hard-to-reach" patient.

Critical to the ultimate success of the neighborhood representative are: the criteria used in their selection and recruitment; the nature of their training; the style of supervision; and their specific role function.

Selection and Recruitment

After understandings of specific neighborhoods were developed, the following selection criteria were established. Neighborhood representatives were to:

1. Be identified with the subcultural group being served.
2. Possess subculturally oriented communication skills.
3. Be a resident of the particular neighborhood, preferably for some length of time.
4. Possess a value for work.[e]
5. Be accepted as a member of the neighborhood.
6. Be socially mobile within the neighborhood.
7. Possess an identifiable value for health care.
8. Not be a member of a group identifiably middle-class.[f]
9. Be over 35 years of age, and female.[g]

Recruitment of neighborhood representatives was particularly time-consuming. The uniqueness of the role and selection criteria eliminated certain traditional sources of manpower. Social agencies (community centers, tenant councils, neighborhood clubs, and the like), supposedly internal to the specific neighborhood provided minimal assistance.

Success came through informal acquaintance with neighborhood residents. Having developed these acquaintances, recruiters were able to proceed from friend to friend until an appropriate selection could be made.

Training

The training philosophy involved the development of the neighborhood representative as a secure semi-independent agent using her natural style and skills. Consistent with the action orientation of the indigenous worker, "doing" and not "talking" was the emphasis. Because of this, training is a dynamic two-way process. Formal classroom sessions and reading assignments were conspicuously absent in the training program. Essentially, training neighborhood representatives has been a continuous problem-oriented process and not a structured program terminated at a certain point.

After a two-day orientation concerned with project goals and philosophy, representatives were immediately involved in unstructured problem-oriented training. This occurred within the specific neighborhoods to be served.

Following several initial visits to stores and homes accompanied by a professional, representatives were sent out "on their own" and were encouraged to discuss the new clinic in a manner natural to themselves. Beyond informing residents of the new clinic, the main purpose of these first visits was to become acquainted with and known to neighborhood families. They were encouraged to spend as much time in a particular home as they desired, enabling them to interact at a meaningful level and to identify individual problems.

From this point the training process evolved from problem identification to problem analysis and finally to problem solving. This process cycle promoted movement from developing simple problem-solving skills to solving of problems of greater complexity. Once one neighborhood representative was functioning, she became the trainer for other neigh-

borhood representatives, thus minimizing the professional trainers' role.

Supervision

Given the unique natural skills of the neighborhood representative and the desire to accommodate the patient group, supervision in the traditional sense has been minimal. Since the representative is in many respects already an expert, supervision becomes a relationship of mutual respect where the representative works "with" the supervisor rather than "for" him. The relationship becomes one in which the representative (rather than the professional) identifies the "need," while the professional merely assists in resolving this need.

Supervision in the more traditional sense occurs at various times. The indigenous worker must be protected from certain middle-class tendencies and discouraged from overidentifying with the professional staff. This occurs in a positive manner by praising the representative for taking a patient's "side" in a case conference or negatively by criticizing the representative for communicating that subtle disdain for low-income patients so often typical of middle-class professionals. This protection is essential until neighborhood representatives become secure in their role and until other members of the professional team accept, and become sensitive to, this role.

Functions

As a relatively independent worker, the neighborhood representative has three functions: that of service expediter, neighborhood organizer, and patient representative.

In the role of service expediter, the neighborhood representative interprets to neighborhood residents the services of the Mother and Infant Care Center and, when appropriate, attempts to solve individual problems of a more immediate nature regardless of whether or not the individual is a prospective patient. Representatives not only become a "link" to needed services, but also demonstrate to the individual being served how to "get things done." In so doing, they enhance the ability of the disadvantaged person to influence and control his environment, a critical step in the accommodation process.

Neighborhood organization, as performed by the representative, occurs in the form of organization for action and for education. Organization for action is accomplished by seeking out neighborhood caretakers who might ultimately be involved in self-help social action projects based on mutually recognized neighborhood needs. As an organizer of persons who "help other people," the representative fosters an increased competence on the part of the socially and economically deprived to cope with neighborhood problems. In so doing, she encourages the development of leadership among the low-income group. A further neighborhood organization function is the establishment of a lay advisory council concerned in part with the operation of the neighborhood Maternity and Infant Care Center. Offered the opportunity to influence clinic practices in terms of appropriate clinic hours, suggesting additional needed services, or advising administrators on the suitability of clinic locations, a greater number of neighborhood residents are involved in and actually influence the accommodation process.

In organizing for education, the representative identifies specific concerns and develops informal gatherings designed to consider these concerns. As these groups develop solidarity and stability, neighborhood representatives are able to direct interest to matters more closely related to the educational goals of the Maternity and Infant Care Project.

As a patient representative, they help patients document their complaints regarding care received during clinic or hospital visits. These complaints in turn are relayed through the appropriate channels and necessary action is taken. This action has at times involved hospital administrators meeting with patients in the ghetto in an effort to resolve specific problems. In one instance pressure created by patient criticism contributed to the resignation of a clinic physician.

Outcomes

In terms of the representatives' ability to resolve some of the problems of traditional concern among public health practitioners, the following evidence is offered. Use of clinic services has shown 42 per cent higher attendance during the same period of time in neighborhoods served by representatives when contrasted with neighborhoods without representatives. Four months after the establishment of a Mother and Infant Care Clinic in one neighborhood, it was determined that in excess of 60 per cent of the patients had been referred by the representative. Clinics served by representatives reported an average of 20 per cent more unwed mothers than in comparable neighborhoods not served by representatives. Of further importance was their ability to recruit expectant mothers earlier in pregnancy. In neighborhoods where representatives have been employed for six months or more, 50 per cent of the patients are being seen in their first or second trimester. This contrasts with 32 per cent in unserved neighborhoods. Although the numbers are small, trends appear to be meaningful.

As an expediter of services to meet immediate needs, the representative has proved particularly effective. Securing food orders and clothing for needy families, accompanying a mentally ill mother during shopping tours, providing transportation to individuals in need of immediate medical attention, contacting immigration authorities concerning certain problems of a family new to the neighborhood, assisting in the appropriation of welfare grants for individuals and families unaware of available funds are examples of the neighborhood representatives' problem-solving functions.

In association with neighborhood "caretakers," neighborhood representatives have organized rummage sales and bake sales. Funds raised were used to resolve various types of financial emergencies arising in the neighborhood. Decisions regarding the specific use of these funds have been made exclusively by indigenous persons. These activities are particularly significant as meaningful examples of the poor actually helping the poor.

Professional staff are frequently involved on an informal basis in activities organized by the representative. In this regard, the professional becomes increasingly sensitive to the disadvantaged individual and begins to destroy the traditional "they" and "we" relationship.

To date, minimal success has been experienced in establishing lay advisory groups or councils specifically concerned with the operation of the Mother and Infant Care Clinics. It is believed that an interest in clinic policy will occur subsequent to the continued accommodation of more immediate neighborhood concerns.

Conclusion

It has been the contention of this paper that the accommodation of prospective patients, in terms of helping to solve immediate needs, must be a component of medical care programs designed to involve the hard-to-reach.

Furthermore, in order for accommodation to occur, public health programs must become "specific" to the particular cultural and economic groups being accommodated. The neighborhood has

been suggested as the appropriate unit for programing in the urban ghetto.

The ability of neighborhood representatives, through their unique role of effectively involving the disadvantaged client in accommodation process, has been documented.

A further consequence of the processes herein described transcends the effectiveness of recruiting the disadvantaged to health care. It is proposed that health care can become a "permeable area"[h] through which the urban poor can move toward participation in the dominant social order. The disadvantaged finds an opportunity, by involvement in health services, to identify and internalize patterns of behavior necessary to more effective participation in society.

Essential to the implementation of the concepts and proposal suggested in this paper, is the sponsoring agency's commitment to the total need of the patient group and a willingness to create programs that go beyond traditional public health practice.

FOOTNOTES

a. The term "medical ghetto" is used to designate not only the complete isolation and alienation of a group from society, but also the isolation from medical care sponsored by the larger society. Generally the medical ghetto is coexistent with the socioeconomic ghetto. However, it is conceivable to have a medical ghetto even without the accompanying socioeconomic alienation. See Miller, S. M. "The American Lower Classes: A Typological Approach." In: Reissman, Frank; Cohen, Jerome; and Pearl, Arthur (Eds.). Mental Health of the Poor: New Treatment Approaches for Low-Income People. New York: Free Press of Glencoe, 1964, pp. 139-154.

b. This concept has been given new emphasis and a process orientation by the writers. Early classical theories on the neighborhood were formulized by: Cooley, Charles. Social Organization. New York: Scribner's Sons, 1915, and Park, Robert. The City: Suggestions for the Investigation of Human Behavior in the City Environment. Am. J. Sociol. 20:577-612 (Mar.), 1915. Studies concerned with empirically investigating the boundaries of neighborhood are scarce. However, see Shenky, Eshrep, and Lewin, Molly. Your Neighborhood: A Social Profile of Los Angeles. The Hayes Foundation, 1949; Hacon, R. F. Neighborhoods or Neighborhood Units? Sociological Rev. 3:235-246 (Dec.), 1955.

c. The recent acceptance of the indigenous nonprofessional in social welfare programs has primarily occurred as a function of two issues. The first being the recognition that certain routine tasks heretofore performed by professionals could be transferred to persons with considerably less academic and professional training. Related to this was the realization that persons in poverty could be prepared to perform these routine tasks, and in so doing be provided an exit from poverty.

Potential problems of these nonprofessional careers is that the very nature of the subprofessional position suggests the involvement of persons who seek the job as a vehicle to escape from poverty—and in so doing begin to alienate themselves from the population they propose to serve. Furthermore, the training of the nonprofessional has tended to superimpose upon these persons certain professionally styled skills at the expense of the further development of natural skills. Oversupervision and the demand for loyalty to the agency further rob the indigenous worker of his potential effectiveness. He becomes, in essence, contaminated, and thereby loses his ability to be effective as an agent of accommodation.

d. Funded by the Children's Bureau, Department of Health, Education, and Welfare.

e. Emphasis was placed on recruiting persons from the working class for several reasons. Unlike the subprofessional who aspires to a professional position, the career path of the neighborhood representative exists only within the confines of this unique role. This factor demands the selection of persons who desire to remain within the neighborhood even though they may be economically able to move. The working-class person is a rather permanent member of the neighborhood and is likely to remain. Furthermore, although the working class has a high value for work, they share the life-style of the low-income group. This value for work is important because much of the neighborhood representatives' activities must be ultimately self-directed.

f. Extensive participation of the prospective neighborhood representative in middle-class organizations may represent their subtle rejection of the subculture and a striving for status —a factor which, if identified by the individual's peers, could cut him off from participation in the culture.

g. The decision to select women over 35 was based on several observations. Generally speaking, the mature woman tends to be more sensitive to the needs of peers than the younger woman. She is less isolated in terms of relationships with individuals and neighborhood groups; she has a greater understanding of "how to get things done," and particularly among Spanish-Americans, she tends to command greater respect.

h. This concept was originally investigated in a report published by the Training Center

for Delinquency Control, University of Denver. (See Kent, James A.; Fliegler, Louis A.; and Ferguson, John R. The Impact of the Spanish-American Culture upon the Production of Juvenile Delinquency. University of Denver (July), 1965.) This was further expanded in a conceptual model called the "Linkman" in which a theory of marginal acculturation is proposed. (See Kent, James A., and Ferguson, John. Improving the Role Function of Disadvantaged Spanish-Americans through the Use of an Intervening Agent. Latin American Research and Service Association, Denver, Colo., 1966.)

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