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REGARDING PUBLIC HEALTH

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I will begin with a favorite phrase of my own from a medical historian named Donald Fleming, "The practice of medicine is a treaty with society." Most physicians realize that patients and society-at-large determine what the patterns of practice and what the over-all structure of medical care are going to be. They determine this jointly with the medical profession and this is a critical thing to understand and recognize.

Physicians, it seems to me, have been curiously silent about some of the problems of deprived populations. If there were an epidemic focus in Cleveland, a disease that killed babies, that doubled the infant mortality rate, that increased the susceptibility to many other kinds of disease both acute and chronic, that impaired learning ability in its victims and left residual physical defects such that large numbers of its victims would subse-

quently be unemployed or be able to take jobs fit only for handicapped persons; a disease that required enormous institutions to house and rehabilitate some of its victims, and a disease that constantly threatened to send pseudopods of one kind or another out into the community; if there were an epidemic focus of a disease such as this in Cleveland or any other northern urban center, I am sure that we would have an anguished howl from the public and a cry to the physicians for the help of the medical profession in its entirety. And I am sure there would be deep concern and deep involvement on the part of the medical profession in reaching into this epidemic focus in researching it, in exploring it, in looking for means of prevention, and for means of therapy and participation in the formation of social policy necessary to control it. The models that come to mind are compulsory immunization, reporting of diseases, quarantine measures, and other steps we are familiar with from other communicable disease of epidemic circumstances.

Well, of course, we have such epidemic foci in every major city. It oversimplifies to say it is an epidemic focus of disease. It is a very complicated set of interactions between people, environment, the dominant society, but the pockets of poverty in particular, the urban ghettos do almost everything I just described. The infant mortality rate in the Hough area is twice the rate for the rest of the city, and that's a very sensitive indicator indeed of the level of health care. A book

which I recommend to all of you, *The Dark Ghetto*, states that Cleveland is the third most segregated Northern city in the United States. Using the percentage of Negro population in the city which lives or has to live in census tracks that are 90 per cent or more Negro, the figure for Cleveland is 54 per cent, or 27 such census tracks, which is exceeded only in Chicago and Baltimore.

I don't have detailed information on utilization or other health indices in Cleveland, but I am sure they follow the patterns which are of most Northern metropolitan centers, and they represent a very real problem about which we as a profession have very often said, "Let George do it" (George being the public health department or others than those primarily engaged in the practice of medicine), or we have recognized that it is a matter of social policy — that ghettos are there in part because there is a threat in the larger society which wants them there, and therefore, is none of our business or we don't really participate — we're not really experts in that we're not medical professionals. Nevertheless it is curious that all the things that are said about ghettos (and if I use the word ghettos and poverty pockets in impoverished populations as being interchangeable it is because they do overlap to such a great extent in our Northern urban areas) one of the least frequently heard is how unhealthy they are as places. Unhealthy not only in physical environment, but unhealthy as social environments in which to raise chil-

dren, and unhealthy in all ways for all the people who live there. Even on the part of official agencies, there is strikingly little activity as compared with this hypothetical epidemic disease I first mentioned — strikingly little activity in terms of health, and health regulations. I am sure, that in this city, if it is like most urban cities, the ghettos are full of unreported violations of the health code. Health code activity against landlords is the least utilized kind of activity.

This is by no means all of it — the very serious set of health problems in deprived populations are the physical environments, but it is equally quite clear that this is not all of it. Here we have all these superb facilities that have been described. There are many of these facilities that are open without significant economic barriers to all those who want to come and use them. We have complicated social mechanisms, welfare ADC and a long list for paying all or some of the costs of medical care for populations like these. And yet, they are not utilized, or not utilized in the ways we think should be utilized; not used effectively from the point of view of the target population that we are interested in. We are all familiar with the mother who never makes a pre-natal visit, or that her first visit to the hospital is at the time of her delivery. So there is no pre-natal care and no identification of the high risk pregnancy and none of the other things that comprise good medical care, although these are available at the out-patient department at the hospital, in health

department sub-centers and the like. We are all aware of the fact that immunization campaigns seem to reach least the people who are least protected, and know of the great pockets in our urban North of children who are not adequately immunized against diphtheria, pertussis, and polio. And yet, response is least from these pockets of deprived population.

Why is this? It is very easy for middle-class people in general and middle-class professionals in particular, I think, to have a more primitive emotional response of irritation, anger, and disgust at people who don't know what is good for them after we have gone through all this effort to make these things available to them. And we are a little puzzled and we find it difficult to undertake more sensible tasks of trying to find out what really is going on. Some of the reasons for under-utilization are very accessible and not very complicated. When the ADC mother of a large family may need pre-natal care for another pregnancy, or maybe when one of her children is sick, it is an extremely complicated business. Let us take pre-natal care for example. It is difficult to find someone to take care of her children, to dress them, get them to a bus, change busses twice, to reach the out-patient department of the city or county hospital; find her way through that maze which makes sense to administrators and medical personnel, but not necessarily to patients; wait for two hours, which is very often the case, to see a physician with limited opportunity for discussion, education, and family interviewing — very often a physi-

cian who has very little conception of the environment from which these people came or the lives they lead. Then the mother must arrange for a return appointment, the instructions for which are not always clear and intelligible. She must come back in two months, follow the same procedure and very often see a different physician, starting all over again with him. There is no way to describe this to make it seem like a very sensible procedure except to the physician or public health technician in the narrowest sense who sees only the objective in terms of pre-natal care. We can say they are not paying for it and people are just going to have to drag their children along. Working class values are quite different from middle-class and professional values. "It's not serious unless it bleeds."

Another example is the hospital emergency room which, in the case of deprived population, represented quite an intelligent solution to some of the delay and waiting problems, except that it broke down as it got too popular. People discovered that you can get treated an awful lot quicker if you go to the emergency room after 5:00 p.m. as opposed to going while the out-patient department is still open. People will find ways to solve problems with you if given the opportunity.

One approach is being tried in Boston under poverty program funds. Let me say that this program seems to have a bad press and seems to be in trouble these days — whatever the merits or deficiencies of the projects it sponsors. It is made up of the only group of people that I have met who work harder than

general practitioners. Most of them have Sunday afternoon off and I know several that start answering their long distance calls at 8:00 at night, which is their first opportunity in their working day to do it. By way of example, we relate the case of a Boston situation with a poverty population and a ghetto, Roxbury, very much like similar neighborhoods in Cleveland, New York and Chicago. A medical school that was interested and had some experience with the continuing relationship with populations like this and wanted to see what it could do to assist decided to take the gamble of getting into direct medical care and to provide service as well as research. A non-categorical agency to the poverty program advised, "We will finance the kinds of things you would like to attempt, not necessarily specifying heart disease, cancer, and others, but just medical care research — a demonstration project." We went through the ghetto and easily identified a study — a housing project of about 7,000 people in relative isolation by definition, because of the rules for getting into housing projects — a poor population, lots of people on ADC, lots of elderly isolated people, lots of babies and young people, about 40 per cent Negro. We decided to see what was involved in measuring the health needs of these people and providing health care for them, and in making some inventions perhaps that would help solve some of their problems.

We had one basic idea, perhaps the most exciting idea the poverty program has brought to this area. The idea was that the target population was going to be a full partner

in what we did, and that we were going to work with *them*, plan with *them*, talk with *them*, see what *they* know, and if *they* are going to have some effective kinds of control over it. That was a radical idea and it frightened me some of the time in carrying it out. We went ahead, and first of all decided a health center would be the core of the health program and that we would try and organize this community — every person in it if we could — into a health association. We decided that the health center ought to be right where the people were because of all of the kinds of problems — very difficult problems in this location in particular — of transportation to existing facilities. I believe that we will get 90 per cent utilization in everything we try and do from this population that is currently using other facilities at levels of 25 to 35 percent utilization. Dues of \$5.00 per year per family were set for membership. When I asked the policy committee of the health association how they arrived at that figure, they said that was the cost of one taxi ride to Boston City Hospital that now won't have to be made because of the health center.

We have the men on the planning of the health facility itself — floor plans, furniture, the kinds of clinics there will be, how the emergency room will work, what kinds of staff seem to make most sense to them, and they are startlingly full of good ideas. We are organized with a very heavy representation of paramedical people, non-physician people to physician people. Our ratio is two public health nurses at

a minimum to each physician and preferably something higher than that. We are going to be in the business very soon of finding local people as community health aides. This is a new role that we are half inventing that combines junior-level social worker, case worker, problem finder, census taker, patient's agent, follow-up worker and all kinds of useful things — this saves enormous amounts of professional time. I think it is this kind of approach heavily involving the target population, with mediacy, with relevance right there or close by. It could be just a store front or a building down the block in the ghetto, I think — tied to a medical school, a hospital, preferably a teaching hospital, an educational institution.

We discussed who was going to pay for it and how, and whether the target population was going to defray the cost. It obviously was going to be token payment. They don't have the means to pay for first-rate quality and comprehensive care, almost by definition. Should it therefore be for nothing? Nobody liked the idea, including the target population. Should it be token? What does token mean? We were not sure, nor were they. Should it be token fee for service? We decided that this was very misleading, indeed. It is said that medical care really should be — comprehensive and continuing, including preventive, pre-natal and all the rest. In addition, it is misleading because in a sense it says this service is worth 50 cents, or that service is

worth \$2.00. At the same time, all those who are receiving medical care through welfare mechanisms which is automatic payment — they will never see a bill or cost item — have no way of determining the actual charges for medical care, what is involved, or how in the future they would ever be able to plan or budget for any part of it. We decided it would have to be token and in the nature of comprehensive prepayment. We suggested to the community through its health association that people might be interested in making comprehensive payment on some sliding scale that would cover annual health service at the center for the family, not a fee for service. Interesting developments ensued. What about people who cannot pay at all? Would it be best to establish a category for those too poor to pay any fee and when they are able to do so will change status? What categories should be determined? The community is deciding this now. Regulations are going to be more stringent than I would have required. The people are so much more knowledgeable that it is going to be very interesting to see how they divide their community in terms of ability to pay.

They wanted to know about comprehensive prepayment. Perhaps one might not become ill and have no need for medical care. We made some parallels with burial and other kinds of insurance with which they are familiar. We suggested that as a measure to prevent sickness, it might be prudent to visit the center for a checkup. People were startled at the idea that there might be a facility

available to them really interested in preserving their health. This was a bargain worth paying for in advance.

I think that utilization of non-professional people, affiliation with a medical school or teaching institu-

tion, participation of the population in planning and execution, use of local people in newly-created roles to assist are new approaches worth trial in the face of these huge problems everywhere.

