

February 1967

Health Efforts of the War on Poverty

Joseph T. English

Follow this and additional works at: <http://epublications.marquette.edu/lnq>

Recommended Citation

English, Joseph T. (1967) "Health Efforts of the War on Poverty," *The Linacre Quarterly*: Vol. 34 : No. 1 , Article 9.
Available at: <http://epublications.marquette.edu/lnq/vol34/iss1/9>

Health Efforts of the War on Poverty

JOSEPH T. ENGLISH, M.D.

Twenty-four short months ago, this nation declared war on poverty. During this period of time we have learned something about the casualties we have suffered because this war was not fought on a national scale before.

As physicians, we have been concerned for years that while the rate of both infant mortality and maternal mortality are falling, the difference between Negro and Caucasian rates is steadily increasing. Before 1920, the rate of maternal mortality was 79% higher among Negroes than Caucasians. In 1963, it was 320% higher. The post-natal mortality rate among Negroes was 80% higher than the Caucasian rate in 1915-19; in 1963 it was 180% higher.

These figures are important indicators that the poor among our people have yet to profit from modern medical knowledge; that the medical services we have learned so well how to give, fail to reach them.

But before the War on Poverty began, we could not have known that 70% of the 20,000 teenage boys and girls who would come to our Job Corps centers would not have seen a doctor for several years; that 90% of them would never have seen a dentist; that they would be, on average, ten pounds underweight.

We did not know that they

would require, on average, 27 visits to the center medical facility each year, often because of a health deficit they brought with them to the Job Corps camp. Nor did we know that more than one-third of them would require eyeglasses because of visual defects never before detected.

We did not know that every single Job Corpsman would require either medical, dental, or psychiatric care at some point during his training, nor did we know that the health of many would be so severely impaired at the time of their application that more than 6% would have to be turned down for medical reasons. The cost of treating their illness or incapacity would be too great for a job training program to support.

And even for those who are admitted to the Job Corps, we have learned that two out of every three Corpsmen would have to spend an average of four days hospitalized in the infirmary each year.

How could we have known that 35% of the pre-school children in poverty entering Head Start programs around the country would never have seen a doctor and that more than 75% of them would never have seen a dentist.

So today, in a country proud of its medical achievements, we need a new emphasis on the programs that are bringing the poor of our country

the health services, the legal services, the educational opportunities that for so long have been beyond their reach.

How can we do otherwise when we know that untreated illness of mind and body is a fact of life to the millions who are poor: that men and women with incomes of less than two thousands dollars a year suffer heart disease at a rate four times greater than the rest of us; that they suffer mental illness, retardation, and nervous disorders at a rate six times greater than the rest of us; and that they have serious visual impairment ten times more commonly than those more fortunate of our citizens.

This prevalence of unattended disease and illness directly affects the economic status of these people, and by so doing perpetuates the vicious cycle of poverty in their lives.

For the poor who are fortunate enough to be employed, almost one-third of them carry such chronic conditions of illness that severe limitations are placed upon their ability to work. That is true of only 8% of the more fortunate of our citizens. No matter how many days we may lose from work because of sickness, that figure is double for the poor — who do not have the benefit of salary, sick leave, or a work environment which will tolerate their absence.

What is this environment of illness and suffering that the average American cannot even begin to comprehend? Why is it that sheer

poverty is considered by some authorities to be the third leading cause of death in our cities? Why are the killer diseases of the poor still tuberculosis, influenza and pneumonia, diseases that we who are fortunate have not suffered for a generation?

Let me place before you the answer given by Dr. Alonzo Yerby, former Commissioner of Hospitals of the city of New York, who told the White House Conference on Health last November, "The pervasive stigma of charity permeates our arrangements for health care for the disadvantaged, and whether the program is based upon the private practice of medicine or upon public or non-profit clinics and hospitals, it tends to be piecemeal, poorly supervised, and uncoordinated. . . .

In most of our large cities, the hospital out-patient department, together with the emergency, provide the basic sources of care for the poor. Today's out-patient departments still retain some of the attributes of their predecessors, the 18th century free dispensaries. They are crowded, uncomfortable, lacking in concern for human dignity and to make it worse, *no longer free*.

To these unhappy circumstances has been added a steady proliferation of specialty clinics so that it is not uncommon for a hospital to boast of 30 or more separate clinics meeting at different hours, five or six days a week. The chronically-ill older patient who frequently suffers from several disease conditions, or poor families with several small children are seen in several clinics which frequently meet on different days. Even if the clinical record is excellent and readily available, it is difficult, if not impossible, for any one physician to know the patient as a person and to coordinate his care.

Dr. Yerby concluded his eloquent address with a call for action which cannot be ignored. He said that America must learn to organize its health system in such a way 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."

Possibly our greatest single need, if we are to make high quality health services available to the poor, is to devise new ways of organizing and delivering these services. In a new program of neighborhood health centers which we are beginning to fund through the Community Action Program of OEO, all personal health services except highly specialized diagnostic services and in-patient care, will be available in an integrated setting which will foster personalized and continuing care but will be readily accessible and responsive to the needs of the persons being served.

Of the eight neighborhood health centers now funded with OEO support, three are already in operation. The first of these to be approved was the Columbia Point Health Center located in a housing project of 6,500 residents in Boston. The center is operated by the Tufts University Medical School in partnership with the Columbia Point Health Association. Located in twelve apartments donated by the Boston Housing Authority and renovated with OEO funds, the center is staffed by a corps of full-time physicians who are on the medical school faculty.

The physicians work as part of a health team which includes non-professionals recruited from among Columbia Point residents and trained by the center. As is the case with other neighborhood health centers, utilization is extremely high and a very substantial amount of previously undiscovered and untreated illness has been revealed. The residents are actively involved in the operation of the center, and have made major contributions in determining the circumstances under which services are provided.

In New York City, an existing ambulatory care unit has been expanded with OEO support to function as a comprehensive health center for an impoverished neighborhood under the auspices of a major teaching hospital. As in other neighborhood health centers, financing has been achieved by mobilization of Federal, State, and local sources of funds. The center is aware of the close relationship between social and medical problems among its patients and attempts to deal with them through joint efforts of social and medical workers. As the medical director of the program put it: "The pediatricians worry far more about school drop-outs and glue-sniffing than about meningitis."

Another neighborhood health center, operating in Denver under the auspices of the Denver Department of Health and Hospitals, was recently featured in *Science*. The article contrasted the center with traditional institutions.

It is open virtually around the clock, with appointments scheduled until 10 p.m. on weekdays, and it has become a kind of hub for other community services from meetings of Alcoholics Anonymous to the offering of free legal aid by the Denver Bar Association. The whole enterprise is suffused with a kind of neighborly spirit that can best be described as "easiness." People waiting to see the doctors at Denver General look like "masses"; at the health center they look like individuals.

Ill health, joblessness, illiteracy, delinquency, family disorganization, and many other components of poverty are inextricably inter-woven. A program directed against any one of these factors can become an entering wedge against all the others. In these terms, health services provide more than therapeutic intervention in the disease processes. They are a

method of social intervention in the more encompassing processes of deterioration and decay which underlie poverty. It is within this context that communities are invited to develop neighborhood health centers of the scope and structure suggested by those demonstration programs already underway.

[DR. ENGLISH is chief psychiatrist, deputy director for health affairs, Office of Economic Opportunity, Executive Office of the President, Washington, D. C. He is also deputy chief, office of inter-agency liaison, National Institute of Mental Health, Bethesda, Maryland; senior psychiatric consultant and NIMH liaison, Peace Corps, Washington, D. C. and assistant clinical professor of psychiatry, George Washington University, School of Medicine, Washington, D. C. This is an address made to the St. Francis of Assisi Guild, Philadelphia, on the occasion of the annual White Mass.]

ADVICE TO AUTHORS

Articles on topics of potential interest to the Catholic physician as a *Catholic and as a physician* are earnestly solicited. A goodly portion of THE LINACRE QUARTERLY readers are not members of the medical profession but are engaged in allied health fields, teach moral theology, or serve in hospitals, and material for their benefit would also be welcome. The subject matter may be predominantly philosophical, religious, or medico-moral in nature. Material should be typewritten, double-spaced, with good margins and on one side of the paper only. Manuscripts (*original and one copy*) should be submitted to the Editorial Office of THE LINACRE QUARTERLY, 1438 South Grand Blvd., St. Louis, Missouri, 63104. One additional copy should be retained by the author. Full editorial privileges are reserved. References if used should appear at the end of the article and should conform to the usage of the *Index Medicus*. (This format is that employed in the Abstract Section of THE LINACRE QUARTERLY.) A brief but pertinent *curriculum vitae* of the author(s) should accompany the manuscript. The Thomas Linacre Award is made annually to the author(s) of the original article adjudged to be the best to appear in THE LINACRE QUARTERLY during each calendar year.