Medicine for the Poor: A New Deal in Denver

Denver, Colorado. One outpost of the War on Poverty that is drawing increased attention from health professionals these days is an unassuming former bakery in the heart of Denver's Negro–Spanish American ghetto known as the Neighborhood Health Center. The Neighborhood Health Center is not the only product of the interest in medicine that is being shown by the Office of Economic Opportunity (OEO). Roughly analogous centers are operating in Boston and New York City, and the OEO has now agreed to fund five more—one in Watts, two in Chicago, one in the Bronx, and one in Bolivar County, Mississippi. So far, the amount of money spent and pledged amounts to less than $10 million, and the number of people eligible for the new services is only about 150,000. But, if the numbers are small, the aspirations of those behind the OEO projects are not. They believe not only that they may rescue medical care for the poor from the "poor law" and charity traditions that have characterized it, but that in doing so they may develop a model that will influence the direction of the rest of American medicine as well.

OEO has gone into the health business for two reasons. The first was a recognition of the reinforcing relationship between ill health and poverty—the realization, in the words of one of OEO's physician-grantees, that "the poor get sicker and the sick get poorer." Inevitably, the agency's involvement in health has in it a measure of political calculation as well. OEO's programs have brought it into conflict with a wide range of political and social interest groups around the country, and as the uproar has increased—and the Vietnam war has been used to justify congressional budget-pruning—the OEO has looked about for activities that fulfill its mandate of liberating the poor without disrupting the Johnson consensus. It was assumed that medical centers would be like Project Headstart—the system of preschools that the OEO is funding throughout the country—and that, just as no one could be against finding places for small children to play learning games, no one could be against finding places where impoverished families already draining municipal welfare and charity resources could go to find medical treatment more convenient and congenial. That calculation was probably wrong. As long as the OEO health centers were viewed as extensions of traditional social welfare institutions for the poor, they drew nothing from existing professional organizations and institutions but a rather benign indifference. Now they are seemingly flourishing, reaching out in new ways, and opposition—chiefly from organized medicine—is clearly on the rise.

At the same time, the neighborhood health centers are finding themselves involved in a very different kind of war. To a certain extent, the doctors who have started them are reformers—even radicals—within their profession. They are fighting decades-old battles—for comprehensive, family-centered, preventive medical care; for group practice; for the development of new kinds of health manpower that cuts across lines made fast by the domination of professional associations and certification and licensing boards. But they are doing all this through the War on Poverty and—at least in Denver—have found themselves confronting radicals with a very different set of priorities, militant leaders (particularly Spanish-American) seeking to use the centers not only to improve the health of their people but to advance their political power as well.

The health center pie has a great many other fingers in it, too. There are a variety of municipal apparatchniks defending established political and bureaucratic jurisdictions, and a number of interested citizens representing local banks, charities, newspapers, real estate interests, and so forth—the group referred to in every city as the "establishment" or "power structure"—that all have an interest in preserving the status quo. In Denver, the bureaucracy and the establishment were slow to grasp the significance of the health center experiment. The obstacles they created were low-grade, the product more of inertia than of opposition. But as the center develops and expands—its sponsors have just applied to OEO for money to fund a second center—the vacuum around the health center is beginning to be filled in, and not all the voices are supportive. At this stage, however, the role of old municipal alliances in the effort to create new health institutions is not yet clear.

Denver's Neighborhood Health Center is in a northeastern part of the city known as the Curtis Park–Arapahoe area (after two public housing projects located there.) The area includes nearly 40,000 people, at least half of whom are classified as living in poverty. Nearly 31 percent of the families have incomes under $3000 a year. Thirty-four percent of those over 25 have completed less than 8 years of education, and 75 percent have less than 4 years of high school. Forty-six percent of the houses are judged substandard or deteriorating. In 1959 the infant mortality rate in the area was 65.1 per thousand; for Denver as a whole it was 58.5. The death rate for Curtis Park–Arapahoe was 16.8; for the city as a whole it was 9.5. About 40 percent of the residents are Negro; about 30 percent are of Spanish or Mexican origin (they are known in the record books as "Spanish surname"); the rest are white. Virtually no physicians maintain offices in the area.

Before the opening of the Neighborhood Health Center last March, Denver's poor were generally treated at Denver General Hospital or at one of a few charity clinics in the city. Denver General is probably neither much better nor much worse than most municipal hospitals. It has suffered during the past few years from the disaffiliation of its medical departments from those of the Colorado Medical Center, a unit of the state university also located in Denver. The disaffiliation, still a rankling issue, was the product of what some people refer to as a "town-gown" fight and others as a successful campaign by right-wing elements in the local medical society. A gradual reaffiliation is now taking place, but, while the academic tie-in may improve the content of medical services, it is unlikely to affect the style in which they are delivered.

For many of Denver's poor, Denver General is inaccessible, separated from their homes by a 60-cent bus fare on a line that is out of service on evenings and weekends. Long waits at depot-like waiting stations take patients away from their other obligations for large chunks of the day. Its clinics are specialized, and there is no one to guide the timid (or the non-English–speaking) through the basement rooms in which they are dispersed. There is little likelihood that a patient will see the same physician twice. There is a complicated fee schedule which demands intensive probings into personal resources to determine the scale of payment for the individual patients, and a kind of assumption that most of the poor must be chiselers. While leading members of Denver's medical society admit deficiencies in the city's provision for treating dental and psychiatric disorders, they claim that the quality of medicine practiced at Denver General is first-rate and that "the people get here somehow when they really need to." The poor refer to it as the "butcher shop," avoid it unless they are painfully ill, and are perhaps as concerned with the personal indignities they encounter (which they are surely capable of judging) as with the quality of the suturing (which they are not).

New Style Service

The Neighborhood Health Center, although it is managed by the city's Department of Health and Hospitals (which also runs Denver General), has managed to avoid almost all these difficulties. Three Volkswagen microbuses, driven by neighborhood residents, pick up and drive home patients who are too ill or too poor to take the bus. An indoor nursery and an outdoor playground, also manned by neighborhood assistants, provide supervised care for well children while their parents or sisters are seeing the doctors. The waiting period is down to proportions more like those experienced by middle-class patients in the offices of private doctors. Every attempt is made to avoid discussing income with patients: efforts are made to check them out with the city's welfare agencies (or with Denver General), but no fee schedule has been adopted and so far all services have been offered free. Efforts are made to insure that not only individuals but whole families have their major point of contact with a single physician. Individual health records are summarized on a family record chart, reminding the alert doctor to ask a mother why she failed to bring her child back for his second shot.

The center's staff of about 130 includes 58 "neighborhood aides"—poor people living in the area served by the center and trained either there or at an earlier training program run by Denver University. These people run the switchboard, the reception area, and the transportation service and are also assigned as assistants to the various medical, dental, and other service departments. At least nine of them speak both English and Spanish and function as translators when the need arises. The center's nonmedical departments include nutrition, health education, social services, and environmental health, and are meant to function as a team, with referrals flowing two ways between the medical and nonmedical areas. There is also a research department that is attempting to develop data about utilization, social attitudes, and so forth. Specialized clinics are being established, but the center emphasizes "family medicine," and most serious and surgical cases are referred to hospitals. The center uses the part-time services of about 30 Denver physicians, drawn both from private general and specialty practice and from local medical institutions, and has a handful of doctors practicing there full-time. 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.

There is absolutely no doubt that the message of the health center is getting through to the neighborhood. By 3 July, the close of the 17th week of operation, the center had seen nearly 7000 individual patients—about 33 percent of the eligible residents. Even more surprising than the rate at which new patients are coming in is the discovery that 21 percent of the patients are individuals who have never been seen at Denver General. That figure should be interpreted with some caution: population calculations are based on the 1960 census, the population in question is fairly mobile, and it is therefore impossible to discover what proportion of that 21 percent represents newcomers. But it is clear that the health center is flooded, receiving over 1000 patients a week—more than twice its anticipated caseload.

Rhetoric or Reality?

Evaluation of the medical treatment that the patients are so enthusiastically receiving is a more difficult matter. Only medically trained evaluators could perhaps arrive at a definitive assessment of how the center's rhetoric—"comprehensive, family-centered care"—squares with the reality. The heavy caseload and the shakedown period have both taken their toll. Samuel Johnson, the young director of public health and preventive medicine of Denver's Department of Health and Hospitals, and the moving force behind the Neighborhood Health Center, readily admits to certain doubts. Johnson, 39, received his medical training at the University of Colorado and a Master of Public Health degree from Harvard in 1960. He is a former professor of preventive medicine at Colorado and still maintains a part-time position there. Johnson wonders whether his doctors are referring to each other as much as they might, and how thorough their examinations are. "What gets on the charts seems too much like what goes on them at large clinics," he commented in an interview with *Science*. "We were aiming for something more. I'm not worried about errors of commission but of omission. We want to do a total job." Nonetheless, Johnson believes that the quality of care is "above average" and certainly equal to that available at Denver General. This view is corroborated by John Sbarbaro, a young physician assigned to the Denver Health Department while on temporary duty with the Public Health Service, and now acting as the center's chief medical officer. "We're sure the care here is average," Sbarbaro told *Science*, "but we want to make it better than average." There is already a weekly analytic "case conference" for the staff and visiting specialists; Johnson hopes to establish an outside visiting committee to review random patient charts as well.

Johnson and Sbarbaro, as well as the OEO in Washington, take particular pride in the fact that the health center was mobilized around rather typical resources such as exist in nearly every American city. Unlike the Boston proj-

NEWS IN BRIEF

• **WHITE HOUSE SCIENCE POST:** At least half a dozen universities with existing or impending presidential vacancies have put out feelers for the services of Donald F. Hornig, the White House science adviser—which may account for rumors that Hornig is leaving Washington. But he appears to be quite happy where he is, and, in fact, in order to stay on for at least a third year he resigned from the Princeton faculty when his leave could no longer be extended. White House sources say that the President has an extraordinary degree of confidence in Hornig and that the job is Hornig's as long as he wants it.

• **POPULATION:** The Department of Health, Education, and Welfare has established a new position, Deputy Assistant Secretary for Science and Population, to coordinate the Department's programs in population planning. The position will be filled by Milo David Leavitt, Jr., formerly head of the special International Programs Section, Office of International Research, at the National Institutes of Health.

• **FDA:** Part-time science advisers drawn from university chemistry departments are being assigned to each of the Food and Drug Administration's 18 district laboratories as part of a program to raise the agency's level of scientific competence. The appointments to date are: Stanley Bruckenstein, University of Minnesota; Donald G. Davis, Jr., Louisiana State University; Robert Ginell, Brooklyn College; Frederick R. Jensen, University of California; Clifton E. Meloan, Kansas State University; Robert L. Pecsok, University of California at L.A.; H. A. Szymanski, Canisius College; and Paul Urone, University of Colorado.

• **DRUGS:** The medical effectiveness of 3000 to 4000 drugs introduced between 1938 and 1962 will be evaluated by the National Academy of Sciences–National Research Council under an $834,000 contract with Food and Drug Administration (FDA). The Kefauver-Harris Amendments of 1962, which now require manufacturers to submit substantial evidence supporting therapeutic claims before receiving FDA approval of new drugs, also call for an evaluation of the efficacy of drugs marketed between those dates, when only proof of safety was required. The study is being organized by the Council's Division of Medical Sciences under the direction of an advisory committee chaired by William S. Middleton, dean emeritus of the University of Wisconsin School of Medicine, and chairman of the NRC Drug Research Board.

• **STATE DEPARTMENT SCIENCE:** The State Department plans to add a science officer to its embassy staff in Yugoslavia, making that the 17th U.S. embassy to include a science officer or scientific attaché. (The duties are essentially the same—keeping abreast of scientific affairs and promoting good relations with local scientists—but the attaché title generally reflects a higher level of professional training.) It has not yet been announced who will fill the Yugoslav post. Meanwhile, a new science officer has been appointed to the Moscow embassy. He is Christopher A. Squire, a Russian-speaking foreign service officer who holds a bachelor's degree in engineering from Yale. His predecessor, Glen Schweitzer, will serve in Washington in the atomic energy section of the State Department's Office of International Scientific and Technological Affairs.

• **EYE RESEARCH INSTITUTE:** Representative John E. Fogarty (D–R.I.), the most influential figure in NIH affairs in the House (he is chairman of the Appropriations Committee subcommittee on Labor, HEW, and Related Agencies), has spoken out in favor of H.R. 12373 to create an Eye Institute at the National Institutes of Health. The bill, introduced by Representative Fred B. Rooney (D–Pa.), would create a separate Eye Institute for the conduct and support of research and training relating to blinding eye diseases and visual disorders. Although the reorganization at NIH has not been spelled out, according to a spokesman at National Institute of Neurological Diseases and Blindness, all vision work at NIH would be centered at the proposed Eye Institute, except in instances in which neurological diseases affect vision. The bill, introduced in January, is pending in the House Interstate and Foreign Commerce Committee.

ect, for example, which is run by Tufts University Medical School and gives Tufts appointments to its staff physicians, the Denver project has drawn only on the local medical community. Now, the fee-for-service mystique is very strong among doctors in this country, and most doctors—particularly those representing organized medicine—are prone to conclude that if the center's salaried doctors relinquish private practice it must be because the services they offer are so bad they are unable to collect the fees. (The center's part-time doctors are paid $7.50 an hour; the full-time physicians average $5.93.) Accordingly, the center has been the butt of numerous charges, mostly made off the record, that its physicians are either incompetents who could not stand the competition or are senile citizens taking it on as a pension while awaiting the pasture. In fact, the center's doctors seem to have rather different motivations. Some are frankly idealists, eager to participate in a novel social experiment. Others are physicians disenchanted with the extensive "management" activities that private practice requires. "There are two things I like about practicing medicine here," commented one center physician. "One is that I can order tests, medicines, referrals, and so forth without worrying about my patient's pocketbook. The other is that I don't have to do any bookkeeping any more. Here I can do what I really want to do. See patients and practice medicine."

The center's medical society critics often seem to be comparing it to some unreal conception of what the alternatives are for the patients involved. One prominent member of the Denver Medical Society interviewed by *Science* complained that the center was inadequate because a mother's prenatal care would not come from the same obstetrician who would deliver her baby in Denver General. In a sense he is right: the division in obstetrical (and other) services certainly reinforces the "depersonalization" in medical care that the center hopes to combat. But the past record suggests that, if it were not for the Neighborhood Health Center, the mother would probably not bother with prenatal care at all.

If all is cheery in the waiting rooms, it has been somewhat less cheery behind the scenes. The problems of the Neighborhood Health Center began early when the original proposal became bogged down in the offices of Sargent Shriver, director of the OEO.

Shriver's objections to the proposal were never made thoroughly clear either to his staff in Washington or to the applicants in Denver, but they appear to have included a feeling that the plan had to be as nearly perfect as possible—both because of the OEO's vulnerability in the Republican-dominated landscape of Colorado and because of the attention-getting potential of the plan as an experiment in medical organization. Working on the other side was a desire to give the poverty program some foothold in Denver, where most of the city's other proposals had already been vetoed as inadequate. Accordingly, the OEO dispatched two medical consultants to the scene. The proposal was then revised—to include, among other things, a greater concentration of resources in a single area than initially envisaged—and, after a time, Shriver reversed himself.

Since then, the health center has functioned without any substantial supervision from either the national office of the OEO or the regional office in Kansas City, neither of which is well equipped to provide the close guidance that the health center's sponsors might have liked. The center was also left pretty much alone by its parent agency, the Department of Health and Hospitals. And it has also functioned largely independently of the metropolitan agency that handles OEO projects, formerly known as Denver's War on Poverty, Inc., recently renamed Denver Opportunity (D.O.).

Denver's Poverty Problems

Nearly all the urban antipoverty agencies in the country have had their difficulties, and Denver is a first-class example. For a variety of reasons—including control by the "establishment," insufficient representation of the poor, weak leadership that is constantly changing (the entire staff has just resigned), and massive disorganization—D.O. has been in exceptionally bad shape. It has managed to sponsor only a few projects, mostly small and mostly innocuous. To all intents and purposes, the Neighborhood Health Center is the only thing Denver has to show for its War on Poverty. And, accordingly, the health center became the focus of community politics and community tensions that in other cities have been spread out among a variety of programs.

The chief factor affecting the political relations of the Neighborhood Health Center with its clientele is the rising militancy of the area's Spanish Americans. In Denver, as in much of the Southwest, Spanish Americans are at the bottom of the heap, considerably below the Negro population in status and opportunity. Negro leadership, reflecting the upward mobility of its community, tends to be relatively moderate. The Spanish-American community, until recently in a state of almost total social disorganization—and lacking in access to the instruments of political power—is increasingly radical and increasingly in a hurry. When the local war on poverty began, it offered Spanish Americans one of their first opportunities to develop and use political power. The opening was the OEO's rhetorical commitment to "maximum feasible participation of the poor," and, because the city-wide poverty agency was virtually immobile, what the poor wanted to participate in was the Neighborhood Health Center. Their vehicle was an advisory board composed of neighborhood residents.

Among the issues raised by Spanish Americans on the advisory board are some with real relevance to the question of whether a medically innovative institution can be fused with a politically radical one. A case in point is a dispute over selection of neighborhood aides. These jobs are crucial to the success of the center both as an operating agency and as an experiment. The neighborhood aides give the center its distinctive character; they make it emotionally accessible to the area's residents; they help reduce the psychological gulf—a product of both class and function—that impedes communication between doctors and patients. As an experiment in "socialization" of the poor, the program seems already on the threshold of success. The jobs are a first step up the social ladder. Offering real responsibilities, not just make-work, they open up possibilities of better jobs in other places: a number of health center trainees are already beginning to move on to jobs with local industries or the municipal career service. The center's professional staff reports numerous instances where neighborhood aides, who entered the program with an attitude of indifference to middle class niceties such as punctuality and neatness, have been transformed by their work experiences. In many cases the personalities and personal relationships are now such that it is difficult for an outsider to distinguish the professionals from the aides. Finally, the aide program is a test of the possibilities of creating new types of medical manpower. Success in this effort does not lie within the reach of the center alone, but the character and calibre of its trainees could play a role in the emerging national effort to soften the boundaries and redefine the scope of the separate health professions.

Can the Poor Participate?

The Spanish Americans, however, are dissatisfied. They claim, accurately, that the aides have been selected not from the poorest of the residents but from among the more flourishing. (The health center was committed to taking on "graduates" of a Denver University training program that included some not-very-disadvantaged residents, including the wife of one state senator.) The Spanish Americans want jobs assigned solely on the basis of need, not on the basis of qualifications or apparent potential. They feel that, without their intervention, the aides would not have been included in the center's employee-benefit plans, and would have been generally less well treated. The center's staff feels it won a major victory in getting the local civil service to accept its graduates without preliminary testing; the Spanish Americans resent the fact that center trainees will still be placed at the bottom of the civil service scale. They are also less than enthusiastic about the part of the center's training program—the medical assistant trainees—that involves preparation for paramedical functions not yet accepted by the medical profession. In this sense, the individual trainees are admittedly being used experimentally; the Spanish Americans want the poor to be able to advance personally. At the same time, they fear that health center jobs are being used to "buy off" potential neighborhood leaders who might otherwise continue to press the city for more reforms. Each side contends that the other is seeking to use the jobs as a form of neighborhood patronage, or for professional or political advancement.

The unrest in the relations between the health center staff and its neighborhood advisory board is focused not so much on the content of particular decisions but on who makes them. It appears that the staff of the center honestly wanted advice: they wanted to know what hours would be convenient, how people felt about paying, what facilities were most needed. They wanted assistance in spreading word

of the center around the neighborhood and in running a ceremonial open house. They did not want to share their authority or to include the poor in substantive policy-making decisions.

The health center is by no means the only poverty agency that has run into this difficulty. Apart from a handful of student activists organizing in the nation's ghettoes, few people have been able to make the jump from benevolence to respect in dealing with the poor. The result is that institutions beginning as efforts to mobilize the poor on their own behalf are constantly threatened with slipping back into an older style of charity, where "we" are trying to "do something" for "them." At the moment, the Spanish Americans on the advisory board seem to have been somewhat neutralized by a minor revolt of Negro representatives who do not share their militance. The present advisers, chiefly Negro women, are relatively passive, seemingly content to plan dinner parties and write letters of thanks to various benefactors, to stay in a subservient place and in the good graces of the professionals. The domination of the board by these elements leaves the center less connected with an important part of its constituency than it perhaps ought to be. The situation may be changed by neighborhood elections to a new poverty board to be held in August, but, if weak representation continues, one of the major bulwarks against turning the center back into something remote and alien from the neighborhood will be gone.

The future of the neighborhood health centers is uncertain. Their cost per patient at this stage is extremely high. (The center is being funded at over $1.5 million a year.) There is a question about OEO's priorities on a national basis. With increasingly limited funds at its disposal, how much should it spend on health? The question of priorities is also important locally, and is becoming an issue in the rising medical society opposition to the health center in Denver. The people in the Curtis Park–Arapahoe area now have access to good, convenient medical care; the rest of Denver's poor are still making the trip to Denver General. The exclusive servicing of a defined population is important for research purposes. It is also obviously inequitable and may even be inhumane. What is a sensible allocation of medical resources? Would it be more fair to use the money, as the medical society would like, to rehabilitate Denver General to provide slightly more satisfactory care for all the people? Or do the experimental aspects of the health center justify the inequalities it inevitably involves? Finally, there is a question of medical politics. The health centers have passed into existence almost unnoticed. Now everyone knows they are there, and pressures—not only from organized medicine, but from Washington health agencies less than eager for the competition—are certain to increase. At this stage the most that can be said for sure is that, while the pleasantness of the neighborhood health centers is now established, their practicality and permanence remain to be proved—ELINOR LANGER

Congress: Old Guard's Leader Is Beaten

Those who have been concerned with preserving historic objects which recall an earlier, simpler time might have done well, had it been technically feasible, to have had the Rules Committee of the U.S. House of Representatives designated a national monument. In the judgment of congressional liberals, the political values that prevailed in the Rules Committee of, say, the 86th Congress (1959–60), had more relevance to a predominantly rural 19th-century America than to the America of today.

This judgment, though perhaps extreme, is supported at least in part by the expressed views of Representative Howard W. ("Judge") Smith of Virginia, the committee's 83-year-old chairman and captain of the Old Guard conservatives of the House. In the last few years the Old Guard, besides suffering the normal attrition that accompanies advanced age, has found the change in the political environment debilitating.

In fact, in Virginia's Democratic primary of 12 July, Chairman Smith discovered that the extent of the changes in his home district had exceeded his ability, and no doubt his willingness, to adapt. Smith was narrowly defeated by a state legislator of little more than half his age, who had campaigned as a relatively liberal candidate. The challenger, George C. Rawlings, Jr., a Fredericksburg attorney, had attacked Smith as a reactionary and obstructionist.

Smith never has hesitated to admit that one of his principal roles in Congress has been to slow down the growth of big government and federal programs. He has used his power as Rules Committee chairman and his acumen as a conservative floor leader to kill or delay legislation that would have authorized the spending of literally billions of federal dollars.

Smith was one of the most important figures in the rearguard action against passage of a variety of aid-to-education measures. His tactics may have held up enactment of the first general school-aid bill by 5 years or more. When Smith has felt unable to block a bill that offended his sense of sound government, sometimes he has succeeded in reducing its size and scope. In 1962, for instance, he got Representative Adam Clayton Powell, chairman of the House Education and Labor Committee, to agree to reject the student scholarship provision in a Senate-passed higher education bill as the price for his cooperation. In this case, an impasse developed between the House and Senate, and no major higher education bill was passed by Congress until 1963.

The Rules Committee, of course, has often played a strategic role in the House because of its power to grant or withhold a "rule" permitting a bill