FROM CONSUMER PARTICIPATION TO COMMUNITY CONTROL OF NEIGHBORHOOD HEALTH CENTERS

by

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ABSTRACT

Title of the Thesis: From Consumer Participation to Community Control of Neighborhood Health Centers

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Submitted to the Department of Urban Studies and Planning in partial fulfillment of the requirement for the degree of Doctor of Philosophy

The dissertation discusses issues of consumer participation and community control in neighborhood health centers, focusing on conflicts between health providers and consumer representatives. The contending parties are defined and an analysis presented of the benefits and deficits of participation and control which are claimed by these opposing groups.

A set of research questions is drawn from a discussion of the most salient issues of participation being confronted by neighborhood health centers and a review of the experience of citizen participation in previous urban programs.

The questions focus upon variables of organizational requirements and ideological positions of the actors rather than upon variables of the local setting in which the centers are located. They probe the nature of the demand for consumer participation and control and its determinants, the modes of influence available to consumers, the operational differences between participation and control, and the effects of different stages of program development and organizational variables on provider-consumer conflicts. Other questions focus upon issues of formal structure vs. actual functioning of the process of participation, strategies of technical assistance to consumer representative groups, implications of participation and control for prospects for broader social change, and the demonstration effects of participation.

A pair of case studies -- of the Denver neighborhood health program and the Yeatman Health Center in St. Louis -- provide a basis for comparing models of consumer participation and community control. Theoretical concepts of political power and influence, requirements

of organizational maintenance and enhancement, and professionalism are used to analyze the development of these two centers and their evolving approaches to consumer participation.

Evidence from the case studies indicates that the demand for participation and control is a complicated mixture of instrumental and end-product goals, of associated expectations about tasks and activities to be undertaken by consumers as well as the extent of their authority. The modes of influence available to consumers were severely restricted. In St. Louis, outside consultants gave consumer representatives access to a broader range of modes; in Denver, the consumers were forced to resort to coercive means in trying to influence the program's development. The process of maturation of each center was found to encourage conflict by placing a shifting set of organizational requirements on both consumers and providers. The cases demonstrated the importance of stressing technical assistance to consumer representatives and of entrusting this function to an agency other than the one operating the center. There were sizable gaps between formal structure and actual functioning of participation. Participation and control tended, in the short run, to relieve outside agencies of pressures operating on them to change, but in the long run appear to be contributing to a significant restructuring of the political interests which determine local and national health policies.

The dissertation concludes by stating the theoretical implications of the findings, offering suggestions for further research and speculating about the future of consumer participation and community control of health care services and facilities.

Name of Advisor: Bernard J. Frieden

Title of Advisor: Professor of Urban Studies and Planning

TABLE OF CONTENTS

	Page
ABSTRACT	
ACKNOWLEDGMENTS	viii
PREFACE	x
PART I: CONSUMER PARTICIPATION AND COMMUNITY CONTROL IN NEIGHBORHOOD HEALTH CENTERS AND OTHER PROGRAMS	1
CHAPTER I -- INTRODUCTION	2
NEIGHBORHOOD HEALTH CENTERS	2
CONTENDING PARTIES	14
Supporters of Greater Consumer Participation	16
Opponents of Greater Consumer Participation	20
BENEFITS ANTICIPATED VS. LIMITATIONS CLAIMED	26
1. Improves program content, delivery and use	28
2. Benefits individual participants	36
3. Supports greater expenditures on health programs for the poor	38
4. Makes programs accountable to their clients	39
5. Fulfills democratic ideals	43
6. Reduces social and political alienation	44
7. Increases neighborhood integration and stability	45
8. Promotes the growth of low-income interest groups	48
9. Equalizes the distribution of political power	50

CHAPTER II -- DEFINITIONS AND THEORETICAL CONCEPTS 52

DEFINITIONS 52

CONCEPTUAL UNDERPINNINGS 59

Political Power and Influence 59

Requirements of Organizational Maintenance and Enhancement 68

Professionalism 71

CHAPTER III -- CITIZEN PARTICIPATION -- THE HISTORY OF AN IDEOLOGY 73

CONTENT OF THE IDEOLOGY 77

DEVELOPMENT OF THE IDEOLOGY 82

The Experience of Federal Programs 87

CONCEPTUAL ROOTS 93

Social and Political Participation 93

Volunteering 97

COMPLEMENTARY, LINKED CONCEPTS 99

CHAPTER IV -- RESEARCH QUESTIONS 105

1. Inevitability of Politics in Neighborhood Health Programs 107

2. Causes of Consumer Demand for Greater Participation 108

3. Main Interests of Health Consumers and Their Support of Innovations 110

4. Provider-Consumer Conflicts over Goals for Participation and Control 112

5. Tasks Associated with Different Goals for and Functions of Participation 114

6. Modes of Influence Available to Consumers 116

7. Conflicts of Consumer Participation Vs. those Related to Community Control 118

8. Effects of Different Stages of Program Development and Organizational Forms 119

9. Formal Structure vs. Actual Functioning of Participation 121

10. Technical Assistance 122

11. Implications of Consumer Participation and Control for Prospects for Broader Social Change 123

12. Demonstration Effects of Consumer Participation 126

PART II: COMPARATIVE CASE STUDIES 128

CHAPTER V -- CASE STUDY STRUCTURE AND APPROACH 129

SIMILARITIES AND DIFFERENCES IN THE CASE STUDY CONTEXTS 130

CHOICE OF RESEARCH METHODS -- WHY CASE STUDIES? 137

CHOICE OF CASES 141

CHAPTER VI -- THE DENVER NEIGHBORHOOD HEALTH PROGRAM 144

INTRODUCTION 145

The Neighborhood Health Program 145

The Community Setting 156

Health Conditions 157

Health Services and Facilities 157

Organizational Framework 158

DEVELOPMENT OF THE NEIGHBORHOOD HEALTH PROGRAM AND CONSUMER PARTICIPATION 163

Opposition in the Medical Community 163

The Lay Advisory Board 169

The First Eastside Health Board 172

The New Eastside Health Board 190

THE MODEL CITIES HEALTH COMMITTEE: A DIFFERENT APPROACH 211

DENVER -- CHRONOLOGY OF MAJOR EVENTS 222

CHAPTER VII -- YEATMAN HEALTH CENTER, ST. LOUIS 226

INTRODUCTION 226

The Health Center 226

The Community Setting 228

Health Conditions 229

Health Services and Facilities 230

DEVELOPMENT OF THE HEALTH CENTER 231

Organizational Antecedents 231

Organizational Framework 237

Planning for the Health Center 240

OPERATING THE YEATMAN HEALTH CENTER -- PROBLEMS OF IMPLEMENTATION 259

ST. LOUIS -- CHRONOLOGY OF MAJOR EVENTS 282

CHAPTER VIII -- ANALYSIS OF THE COMPARATIVE CASES -- ANSWERS TO THE RESEARCH QUESTIONS 283

1. Inevitability of politics in Neighborhood Health Programs 285

2. Causes of Consumer Demand for Greater Participation 288

3. Main Interests of Health Consumers and Their Support of Innovations 292

4. Provider-Consumer Conflicts over Goals for Participation and Control 295

5. Tasks Associated with Different Goals for and Functions of Participation 300

6. Modes of Influence Available to Consumers 305

7. Conflicts of Consumer Participation vs. Those Related to Community Control 306

8. Effects of Different Stages of Program Development and Organizational Forms 310

9. Formal Structure vs. Actual Functioning of Participation 320

10. Technical Assistance 322

11. Implications of Consumer Participation and Control for Prospects for Broader Social Change 324

12. Demonstration Effects of Consumer Participation 328

CHAPTER IX -- CONCLUSIONS 333

PRINCIPAL FINDINGS 333

THEORETICAL IMPLICATIONS 337

SUGGESTIONS FOR FURTHER RESEARCH 340

A LOOK AHEAD 346

APPENDICES:

A. METHODOLOGY 354

STUDY PROCEDURES 354

Interviews 355

Other Materials 365

GENERALIZATION FROM THE FINDINGS 365

B. DISTINGUISHING BETWEEN CITIZEN PARTICIPATION AND CONSUMER PARTICIPATION 367

C. DENVER -- LIST OF PRINCIPAL ACTORS AND ORGANIZATIONS 378

D. ST. LOUIS -- LIST OF PRINCIPAL ACTORS AND ORGANIZATIONS 381

BIBLIOGRAPHY 383

BIOGRAPHICAL NOTE 398

LIST OF TABLES

		Page
TABLE VI-A	1969 NEIGHBORHOOD HEALTH PROGRAM GRANT EXPENDITURES, BY SOURCE OF FUNDS	148
TABLE VI-B	DENVER DEPT. OF HEALTH AND HOSPITALS TOTAL EXPENDITURES FOR 1969 AND BUDGETED FOR 1970	149
TABLE VI-C	PERCENTAGE DISTRIBUTION OF PATIENTS BY RACIAL AND ETHNIC GROUPS	150
TABLE VI-D	NEIGHBORHOOD HEALTH PROGRAM PERSONNEL BY JOB CATEGORY	155
TABLE VII-A	SELECTED DEATH RATES IN YEATMAN COMPARED TO THE NATIONAL MEDIAN	229

LIST OF FIGURES

		Page
FIG. VI-A	LOCATION OF FACILITIES, NEIGHBORHOOD HEALTH PROGRAM	153
FIG. VI-B	ORGANIZATIONAL RELATIONSHIPS, NEIGHBORHOOD HEALTH PROGRAM	159
FIG. VI-C	ORGANIZATIONAL RELATIONSHIPS, MODEL CITY MENTAL HEALTH PROGRAMS	212
FIG. VII-A	HEALTH FACILITIES IN AND AROUND THE YEATMAN DISTRICT	232
FIG. VII-B	ORGANIZATIONAL RELATIONSHIPS, YEATMAN HEALTH CENTER	236
FIG. VLL-C	LINES OF AUTHORITY WITHIN THE YEATMAN DISTRICT WITH REGARD TO THE HEALTH CENTER	239

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PREFACE

Issues of consumer participation and local control are topics of fervent exhortation and fierce debate among urban planners and related professionals, but rarely subjects of careful empirical analysis. For many persons in the field, the concepts which march under these banners are articles of faith and items of basic political orientation which avoid academic scrutiny. I share the commitment to broader citizen participation in public affairs and expanded community control of public services. It is precisely for this reason that I have chosen to study these issues.

The focal issues that stimulate this inquiry may be summarized as follows:

1. Participation vs. control

What differences in a neighborhood health program are caused by whether it is characterized by consumer participation or by local control?

2. Transitions from no consumer role to consumer participation and control

What is the process by which neighborhood health programs move from no consumer role to consumer participation, and from consumer participation to community control? What administrative

factors influence this evolutionary development? What are the organizational determinants of conflict about consumer participation and how do they operate? How are stages in the development of a neighborhood health program related to the growth of consumer participation?

3. Functions and objectives of participation and control

What functions -- positive and negative -- attributed to consumer participation and community control are fulfilled in neighborhood health programs? How do these functions change in the process of program development and implementation?

It will be noted that the dissertation deliberately does not emphasize two widely debated issues: Should there be more extensive consumer participation? What factors in a given community setting encourage organization of consumer participation and which impede it?

ORGANIZATION OF THE DISSERTATION

This piece of research begins in Chapter I with an Introduction to the politics of neighborhood health programs and outlines legislation relevant to these projects. Chapter II defines the key terms used in the inquiry and introduces basic concepts.

Chapter III provides an historical overview of citizen participation in order to provide background, to clarify issues and to generate more specific research questions. The academic literature on the subject has been sparse, but recently has expanded very

rapidly. Because consumer participation in neighborhood health planning has its roots in the experience of other governmental programs, it is imperative to use that experience extensively. Urban researchers have looked at different sets of questions and have employed a variety of study methods. A great deal can be learned by carefully sifting through what has already been done and recasting it in terms of the interests of this dissertation. In order for the dissertation to contribute as much as possible to the development of a theory of consumer participation and community control, the inquiry must flow from that body of experience.

The next step in the research is the elaboration in Chapter IV of research questions applied specifically to neighborhood health programs. The answers arrived at will have significance beyond the area of health care.

The empirical component of the dissertation lies in a pair of comparative case studies (Chapters VI and VII) of the Denver neighborhood health program and the Yeatman Health Center in St. Louis, the framework for which is provided in Chapter V. These programs differ in a number of basic ways, but provide an excellent context for comparing contrasting paths of development, the consequences of a consumer participation model vs. a community control model of administration, and the relation of these models to the programs' respective conflict-oriented vs. consensus-oriented politics.

The cases are written so as to give the reader an intimate knowledge of the process of development of each program along the dimensions of particular interest here. In addition, each case yields data on the set of questions which guide the analysis. Following the cases, Chapter VIII compares the experiences of the two programs. The concluding chapter summarizes the research findings, states their consequences for theories of political power, professionalism and organizational determination. Modifications of existing theory are suggested and a set of new questions outlined to guide further research. Finally, there is a speculative look ahead, including a short-run prognosis of probable choices among policy alternatives and a discussion of the expected impacts of major social and medical trends on the longer-range prospects for consumer participation and local control in neighborhood health programs.

ORIGINS AND ORIENTATION

The origin of my interest in citizen participation in health planning dates to the fall of 1966 when I was hired as a research assistant by William W. Nash, Jr., of the Harvard Department of City and Regional Planning, to work on a Public Health Service-sponsored project studying possible relationships between city planning and health planning. Bernard Frieden was co-principal of that study. The project was charged with exploring ways and means for the fields and practitioners of city planning and health

planning to better integrate or interrelate their work.[1]

One of my own contributions to the project was a paper on "Citizen Participation in Health Planning."[2] Through a review of the literature on citizen participation in various city planning contexts and programs, and an exploration of issues in the organization and delivery of health services and facilities, I sought to apply the experience of city planners with this elusive concept to the emerging problems and opportunities confronting the developing field of health planning. At that time, my involvement with the subject was fueled by a keen interest in and commitment to the potentialities of citizen participation in planning urban development. I was close to a true believer in the concept, and endorsed potential benefits cited by advocates of substantial citizen participation. Before entering graduate school, I had worked brief periods for urban renewal agencies in New Haven, Connecticut, and Oakland, California. As a result of teese jobs I felt a sort of crusading zeal on behalf of such programs. Their approach to citizen participation was a major factor in my enthusiasm. My early graduate work on the topic broke this wholehearted embrace of the doctrine.

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[1]U.S. Public Health Service Exploratory Research Grant #5-R21 CH 00222-02 HSRI. January 1966 - December 1967.

[2]In William W. Nash, Jr., and Bernard J. Frieden (eds.), Planning for Health Services and Facilities and Its Relation to City and Regional Planning Activities. (Cambridge, Mass.: Joint Center for Urban Studies of M.I.T. and Harvard, 1968), pp. VI-1 to VI-64.

This earlier look of mine at citizen participation in health planning benefitted very little from any direct field work or exposure. The literature on citizen participation in health programs was almost nonexistent except for a few exhortatory pieces and sales pitches by persons associated with the first neighborhood health centers which were just opening in 1966.

When I took up the subject again in the fall of 1969, it was with the intention of carrying the inquiry much further. The dissertation would be an opportunity to elaborate and to refine hypotheses and to test them out. By then there was much more extensive local experience with neighborhood health programs generally, and with the attendant political struggles over consumer participation.

The literature on citizen participation in health planning was still sparse, but was suggestive and instructive. Major projects were under way studying various aspects on consumer participation in the process of planning and running health programs. An area of inquiry was beginning to take shape, a body of ideas was emerging which provided a foundation upon which to build as well as to contribute to.

By this time my attitude toward citizen participation was much less sanguine. I was sympathetic with many arguments advanced on behalf of the concept, but was skeptical and unconvinced on several points. I felt some strong criticisms of citizen participation and saw clearly what I considered to be inherent limitations. I maintained a strong ideological commitment to many

of the objectives stressed in its behalf. I was troubled by much of the practical experience to date with different approaches, modes and requirements aimed at fostering the goals of citizens' involvement in planning and running public programs, but felt optimistic about a few instances where it seemed to be working more consistently. I approached the dissertation with ambivalent attitudes toward these issues, but with a strong desire to try to find out more about them.

The orientation of social planning and social policy is a happy one given the questions which guide the inquiry. The existing knowledge and the research tools of urban planning and social policy are aptly suited to the task because the issues are truly interdisciplinary in scope. A number of different professions are involved in planning and running these programs. Evaluation of the programs which accurately measures the confusing variety of costs and benefits of different approaches must proceed from the wide-angle vision of social policy which integrates considerations from different social sciences and emphasizes the interrelationships between variables of government policy, organizational arrangement and social structure. The questions are dilemmas of political controversy, not medical science. The thesis leans heavily toward political science for its theoretical guidance, but is grounded in the emerging field of social policy. The developing concerns of social policy as a coherent body of knowledge and an approach to inquiry are coincident with the issues which motivate this dissertation. These include a

preoccupation with the distribution of resources both in terms of services and facilities made available to different sectors of the population and in terms of the loci of control over decisions about these resources. Another primary concern for the field is the evaluative comparison of competitive approaches to a social problem or set of needs. An empirical look at these issues of consumer participation and control feeds into the continuing effort to determine the efficacy of this route to social improvement and to choose among different vehicles for driving along it.

There exists a great deal of mythology about the objectives and functioning of consumer participation and community control. Many of the romanticisms are seductively attractive, but they cannot be surely possessed until we realize their true nature more accurately. There is a tremendous need to move beyond exhortation and toward more hard-nosed empirical work in this area, because some of the mythology may in fact be true, and until its veracity is more surely established, the future of these truths promises to be like that of a legend which enjoys a brief period of popularity and then an early disappearance from our folklore.

Hopefully, this analysis will lead to a clearer understanding of the prospects and problems of consumer involvement. The study falls within Martin Rein's category of the "institutional performance" perspective on questions of social science and the elimination of poverty.[3] As such it should be helpful to health administrators

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[3]Martin Rein, "Social Science and the Elimination of Poverty," Social Policy: Issues of Choice and Change (New York: Random House, 1970), pp. 417-445.

confronted with hard choices about whether and how to decentralize authority. There are clear alternatives, although it is often hard for administrators to conceive of themselves as actually having choices open to them as they move from crisis to crisis on a daily basis.

We are in the midst of continuing, basic debates of social science as applied to public policy: services vs. income strategies of social betterment, culture of poverty vs. situational determinants of the behavior and attitudes of poor persons. By studying a particular set of issues surrounding consumer participation in a specific type of program in one functional area, health, this project can shed some light on these ongoing controversies. It deals peripherally with a number of them by attempting to answer the research questions outlined in a following chapter.

This dissertation proceeds from a deep, though at times desperately grasping, commitment to the possibilities for radical institutional changes in this country. It is motivated by a desire to avoid an enfolding of currents about which John Gardner, in an imaginary look backwards, wrote: "The reformers couldn't have been less interested in the basic adaptability of a society that posed tough and complex tasks of institutional redesign, that bored them to death. They preferred the joys of combat, of adversary relationships or villain hunting."[4]

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[4]Richard R. Wolfe, "Individual Participation in Governmental Decisions," Bulletin of the Atomic Scientists (December 1968), p. 32.

The progress of consumer participation and community control represents a continuing revolution in the relationship between citizen and government. The speed of this development makes labelling it as revolutionary an accurate characterization. Studying such developments can be a mode of sitting safely on the sidelines, but -- as I obviously believe -- it can also play a critically important role in sustaining that development by providing a clearer understanding of the why's and how's of progress to date.

PART I: CONSUMER PARTICIPATION AND COMMUNITY CONTROL IN NEIGHBORHOOD HEALTH CENTERS AND OTHER PROGRAMS

CHAPTER I - INTRODUCTION

NEIGHBORHOOD HEALTH CENTERS

The federally-assisted neighborhood health centers established in the last four years in U.S. cities represent a dramatic experiment in new institutional forms for the delivery of health care services to low-income areas. These centers have experienced an evolving set of federal requirements and health consumer demands for consumer participation in, and community control over, the new facilities. Issues of consumer participation -- how much? organized in what ways? -- have become items of intense debate and controversy. These conflicts are having a vital impact on the future of individual programs and upon the structures and exercise of political influence in the whole health field. The claims advanced pro and con more extensive consumer participation are in the aggregate a very important group of anticipated functions and dysfunctions about which we know very little. The issues involved lie at the root of pressing dilemmas of how we go about planning for improvements in a variety of public services and areas of life -- education, police, commercial development, and housing, to name only a few.

Who is demanding greater consumer participation in the planning and operation of neighborhood health programs? Why? What

is the nature of the demand? Who opposes greater consumer involvement and for what reasons? How do health agencies and institutions respond to the demand? Following a description of the federal programs which are the focus of consumer participation efforts in neighborhood health, this dissertation is introduced by a description of the groups allied for and against greater consumer participation and a summary of their respective arguments pro and con. Their contentions outline the functions and objectives intended for participation and those which skeptics fear will emanate from the process of consumer involvement. This analysis lays the framework for an empirical examination of some of the determinants of conflicts over consumer participation and control and of the extent to which the positive and negative functions attributed to participation are fulfilled by the process as it actually occurs.

Consumer demands for participation in health planning affairs have been directed at other institutions as well as neighborhood health centers. Consumers militate for representation and majority membership on the Boards of Directors of municipal hospitals, they have challenged the ways in which comprehensive area-wide health planning agencies have met the federal requirement that half of the membership of their boards be consumers. This dissertation is limited to participation in the context of neighborhood health centers, but the issues examined parallel those surrounding demands for participation in other agencies and institutions as well.

The first neighborhood health centers (also called Comprehensive Health Services Programs) were sponsored by the Office of Economic Opportunity and funded under the general provisions of the Community Action Program section of the establishing legislation of the anti-poverty program. Initial grants were made for centers at Columbia Point in Boston, Denver's Eastside (subject of one of the case studies of this dissertation), and the Beth-Israel Medical Center in New York City. A second set of grants were made to establish neighborhood health centers in Chicago, Los Angeles and New York City. These early demonstration projects had considerable impact on the guidelines which directed the development of centers of more recent vintage. Their successes justified extension of the experiment through a Congressional amendment of the Economic Opportunity Act, submitted by Senator Edward Kennedy in 1966, which authorized OEO to fund neighborhood health centers.[1]

Through 1968, 48 projects received funds from OEO. Most continue to receive OEO support. The centers have in common the objective of providing some measure of comprehensive health care services under one roof at a location easily accessible to poor residents and delivered in a manner acceptable and attractive to them. In accordance with OEO 's desire to experiment with

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[1]Economic Opportunity Amendments of 1967, Title II, Sec. 222.

different kinds of programmatic approaches, the centers are sponsored by local municipal health departments, medical schools, voluntary hospitals, medical societies, prepaid group practices, a fee-for-service group and local Community Action Agencies. Their patient populations vary from 6,000 to 50,000.[2] The OEO guidelines call for simplified procedures for determining patients' eligibility, and for the development of "continuous personalized relationships" between health staffers and patients.[3] Each center is expected to provide a specified minimum range of services and to make arrangements for referrals to other sources of more specialized care, and methods for following these referrals. Many offer a wide variety of related social services in addition to primary medical care and preventive medicine.

Patients are to be provided ways of participating in the planning and running of the centers through a variety of mechanisms ranging from membership on advisory councils or controlling boards to employment of neighborhood residents at the centers themselves. The OEO legislation instructs that the Neighborhood Health Center program is

> To assure that services are made readily accessible to the residents ... are furnished in a

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[2]Donald L. Madison, "Organized Health Care and the Poor," Medical Care Review, Vol. 26, No. 8 (August 1969), p. 785.

[3]Health Services Office, Community Action Program, Office of Economic Opportunity, "The Comprehensive Neighborhood Health Services Programs," Guidelines #6128-1 (March 1968), p. 16.

> manner most responsive to their needs and with their participation...[4]

The Guidelines prescribe the following functions for consumer advisory groups:

> The neighborhood health council shall participate in such activities as the development and review of applications for OEO assistance, the establishment of program priorities, the selection of the project director, the location and hours of center services, the development of employment policies and selection criteria and fee schedules, the selection of neighborhood resident trainees, the evaluation of suggestions and complaints from neighborhood residents, the development of methods for increasing neighborhood participation, the recruitment with other community groups and other matters relating to the project implementation and improvement.[5]

The degrees of influence over neighborhood health center policy exercised by these advisory groups vary considerably.[6] A wide range of approaches to selecting consumer representatives and of organizational arrangements for their participation are used by different centers.

A smaller number of neighborhood health centers, of basically the same design and objectives, has been sponsored by the Public Health Service of HEW operating under Section 314 (e)

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[4]Economic Opportunity Act of 1964, as amended, Section 222 (a)(4).

[5]Health Services Office, op. cit., p. 6.

[6]Gerald Sparer, George B. Dines and Daniel Smith, "Consumer Participation in OEO-Assisted Neighborhood Health Centers." (Unpublished paper, November 13, 1969.)

of the Public Health Service Act as it was amended in 1967. This Section does not authorize, as does the Economic Opportunity Act, expenditures for this specific kind of institution, but is available for assistance to community health service projects. Since the Public Health Service has given top priority to improving the health care of the poor through this section, it has been used primarily to finance neighborhood health centers. The major difference of the HEW centers from those sponsored by OEO is that four centers (Oakland, Hunts Point in the Bronx, St. Louis, and Manhattan's lower East Side) are operated by local community corporations who receive funds directly from the PHS.

A variety of other federal programs provide health care services to low-income areas, but they do not carry the requirements and possibilities for consumer participation which are tied to the neighborhood health center concept. These include the Children and Youth programs and Maternal and Infant Care projects sponsored by the Children's Bureau of HEW. Model Cities programs have involved considerable consumer participation in the planning of health components in some cities,[7] but these programs were not

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[7]May Hipshman, "The Mental Health Program of the Denver Model Cities Program," and "The Model Cities Better Health Corporation, Atlanta, Georgia." (Unpublished case studies undertaken for the M.I.T. Department of Urban Studies and Planning, June 1970).

Leighton Whitaker, "Citizen Participation in Community Mental Health Programming," presented at the NIMH Career Teacher Conference, February 13, 1970.

_____, "Social Reform and the Comprehensive Community Mental Health Center: The Model Cities Experiment," presented at the annual meeting of the American Public Health Association, November 12, 1969.

far enough along to be examined as part of this study.

The recent growth and development of neighborhood health programs in the U.S. has occurred in response to a mixture of pressures and trends in the field of health care and in the broader society. The neighborhood health center movement is a confluence of elements of self-help and community action. It intertwines retreating professionalism and paternalism in social welfare with impulses toward decentralization of authority and of services and facilities. The trend toward experiments in decentralized medicine is expressed most vividly in the concept of the neighborhood health center.

The centers have developed partly in response to a set of patient complaints and grievances which are expressed in almost uniform fashion in low-income areas across the country. Existing health care services and facilities within the means of poor people are hard to reach -- they are often far away from low-income residential areas, public transportation to them is costly and hard to use. Patients regularly experience discourteous treatment from medical personnel at hospital clinics. The services available are uncoordinated -- patients have to go to different facilities according to the type of ailment they have, or their age and other personal characteristics defining their eligibility for a particular source of services. Meeting eligibility requirements is often a difficult and degrading process. The quality of care is unacceptable. Services are discontinuous -- one sees

different medical personnel on successive visits. The physical facilities are overcrowded, their atmosphere gloomy and oppressive. The neighborhood health centers have sought to overcome these deficiencies by creating new institutions for the delivery of health care and by modifying existing facilities.

Anselm Strauss outlines the dismal and pessimistic view of medical care available to the poor:

> Large buildings and departments, specialization, division of labor, complexity, and bureaucracy lead to an impersonality and an overpowering and often grim atmosphere of hugeness.... The poor, with their meager experience in organizational life, their insecurity in the middle class world, and their dependence on personal contacts, are especially vulnerable to this impersonalization.[8]

He argues that medical care for the poor must be reorganized so that it accepts the life styles of the poor in order for them to have anything approaching equal care. "Nothing in current legislation or planning will accomplish this."[9] The routes to reform which Strauss specifies can be approached through greater consumer involvement in the neighborhood health programs and centers. These include: improving the accessibility of health facilities, making the first visit of a patient easier, improving initial experiences in medical facilities, and improving communica-

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[8]Anselm Strauss, "Medical Ghettos," Trans-action, Vol. 4, No. 6 (May 1966), p. 10.

[9]Ibid., p. 8.

tions about medical prescriptions.

John Stoeckle points out that health care for the poor in this country has always required special solutions. The reasons underlying this separate treatment have included: limited economic resources and a philosophy of reform which assumed that it was fine for the poor to remain poor, so long as they were healthy. Historically, our approach to improving the care of the poor has been to make it more accessible, a theme resuscitated by the neighborhood health centers of today. Our philosophy has changed so that now we reject this limited goal and hold as a primary objective that better health care should help the poor to emerge from poverty.[10] This new goal adopts the cycle of poverty theory, but sees health as a point of intervention that can or should be exploited by itself. Health reformers endorsed the idea of health as an appropriate point in the cycle at which to intervene, but many of them have rejected the strategy of linking health improvement with another wedge being driven into the cycle and directed at the powerlessness of the poor.

The neighborhood health centers are not an entirely new institutional form. Around 1910 U.S. public health officials desired greater coordination of the separate categorical clinics

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[10] John D. Stoeckle, M.D., "The Future Health Care," in John Kosa, Aaron Antonovsky, and Irving Kenneth Zola (eds.), Poverty and Health. A Sociological Analysis. Cambridge, Mass.: Harvard University Press, 1969, pp. 292-3.

which existed in many cities for ministering to the poor. The movement toward coordination brought together, under one roof, in neighborhood locations a variety of preventive services (VD, tuberculosis, vaccinations for children, nutrition programs), but only occasionally included treatment services as well.[11]

A primary stimulus for the development of these centers, which began around the turn of the last century, was an overriding professional concern with efficiency. This motivation contrasts sharply with the trends which have sustained the present-day neighborhood health centers movement. The current trend is based more on fulfillment of humanitarian ideals, but some of its supporters claim that the neighborhood health centers will also be more efficient.

Stoeckle takes an immensely provocative and revealing historical look at the historical determinants of this earlier generation of neighborhood clinics. His analysis lends credence and weight to the arguments of those who point to the negative aspects of the selectivism of the neighborhood health centers. We are left wondering whether the vulnerabilities of these earlier neighborhood health units are a sort of genetic defect which has been transmitted to the modern-day federally-assisted centers. Stoeckle suggests that the neighborhood centers may be "institutions of transition," to another form of delivering health care which will

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[11] Ibid., pp. 301-303.

be more broadly institutionalized.[12]

It is interesting to review the reasons why that earlier generation of neighborhood clinics passed away, because they may foreshadow problems of the current model. The factors in their demise included: patients' growing ability to use private doctors, private sources of care doing more in the way of preventive care for children, technical advances such as the invention of penicillin, lack of adequate integration with other medical institutions, and difficulty in recruiting doctors. Of course, the new generation of health centers is different in important ways -- their greater size and the variety of institutions which sponsor them, for example.[13] However, the current centers are supported by federal grants which are intended to be systematically reduced year by year. They are expected to be self-sustaining after five years, and most of the centers are now desperately worried about their financial future. They must hope that some one or some new program will be forced to bail them out.

In one particularly experimental program during the earlier era of neighborhood clinics, the Cincinnati "social unit" experiment, representatives of the public were included in the management of the programs, with the aim of increasing public interest in

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[12] Ibid., p. 315.

[13] Ibid., p. 304.

health affairs. Other clinics of that period attempted some form of consumer participation.

> Many health centers attempted to involve actively the neighborhood residents in their programs, but attempts to organize people of the district themselves into a local council ... has generally yielded little result in proportion to the effort expended. The reasons for the difficulty lie deep in the characteristics of American neighborhood life whether among native or foreign born.[14]

The recently developed neighborhood health centers have grown during a period of public alarm over public health conditions. The middle and late 1960's saw a spate of muckraking magazine articles about the medical profession and the quality of health care in the U.S.[15] This critical publicity coincided with a public mood supportive of proposals for extensive changes in health care institutions and financing. It is perhaps a natural and logical consequence of the growing governmental involvement in supporting health care that issues of consumer participation are so current. The federal government's support of health care programs has increased steadily since the passage of the Social

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[14] Ibid., p. 305, quoting Michael M. Davis, Jr., Clinics, Hospitals and Health Centers (New York: Harper and Bros., 1927).

[15] Early examples of these articles include:

"Crisis Now Near in Medical Care?", U.S. News and World Report (March 7, 1966), pp. 38-41.

"RX for Sick Hospitals," Newsweek (July 11, 1966), pp. 57-61.

R. Tunley, "America's Unhealthy Children: An Emerging Scandal," Harpers (May 1966), pp. 41-46.

Security Acts in 1935 which authorized grants-in-aid for maternal and child health programs, and for state and local health departments. A second period of expanded federal support followed World War II with the enactment of the Hill-Burton Act to finance hospital construction, establishment of the National Institute of Health to underwrite medical research and a variety of health manpower bills. This era of federal investment in health was based on a resource-base strategy which assumed that the government's obligation stopped at guaranteeing an adequate supply of the necessary facilities, knowledge and manpower to support the health care system, and that individuals would finance their own way within this system.[16] During the presidencies of John F. Kennedy and Lyndon B. Johnson, the government's commitment to health was extended to endorsing adequate care as a basic human right and began to provide more extensive assistance in the securing of care, making it available to groups of persons who previously had limited access to health services.

CONTENDING PARTIES

Allied in support of greater consumer participation in neighborhood health centers tend to be: (1) health consumers and their representatives, (2) some anti-poverty program employees,

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[16] William Kissick, presented to Harvard Department of Economics graduate seminar on "Medical Economics," November 18, 1969.

and (3) consumer-oriented health professionals. Opponents of more substantial participation include: (1) established health care agencies and institutions, (2) some anti-poverty program employees, and (3) provider-oriented health professionals, including health reformers with other approaches to change.

In local communities, these groups conflict over such issues as how much influence should be exercised by consumer representatives, how consumer participation should be structured, and what functions it should attempt to perform. A key source of the differentiation of the opposing sides is their varying allegiance to professional values and the content of these values.[17] Professionalism by definition means regarding members of the profession as the ultimate source of guidance for behavior in the given sphere of work. Supporters of greater consumer participation maintain less of a commitment to professional values with regard to sources of legitimacy and loci of authority than do their opponents. However, both advocates and critics of greater participation often share the professional values of standards of professional work and the criteria for judging this work.

A second underlying reason for the differences among the contending parties are conflicts in their self-interests.[18] Since

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[17] I am indebted to Larry Susskind for this observation.

[18] George A. Goldberg, Frederick L. Trowbridge and Robert C. Buxbaum, "Issues in the Development of Neighborhood Health Centers," Inquiry, Vol. 6, No. 1 (March 1969), p. 42.

these interests may be furthered or inhibited by more extensive consumer participation, the contending parties respond to proposals for greater participation accordingly.

SUPPORTERS OF GREATER CONSUMER PARTICIPATION

The category, health consumers, includes a wide variety of community organizations and national bodies who represent the interests of minority groups and low-income citizens. In 1965, Lisbeth Bamberger could write that no organizations existed which were specifically devoted to bettering the health of Negroes. Organizations devoted to the goal of equal opportunities and rights for Negroes seldom discussed or emphasized the inequities in health. The one significant achievement of civil rights groups with regard to health was the NAACP's legal victory over the separate but equal provision of the Hill-Burton Act.[19] More recently, black groups have taken an active interest in health issues. At the local level, they have pushed hard for community control of neighborhood health programs.

The War on Poverty has fostered the development of a sizable class of social workers, community organizers and other anti-poverty personnel who support demands for greater consumer participation in neighborhood health centers. Persons in this group have

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[19] Lisbeth Bamberger, "Health and Ethnic Minorities in the Sixties," American Journal of Public Health, Vol. 55, No. 4 (April 1965), p. 496.

worked hard to gain a greater citizen's role in public policy-making. Many of them were first involved in anti-poverty programs as service recipients or as citizen advisors before they were hired to work for the programs themselves. They maintain this earlier allegiance. Some might be labelled "professional participants" by virtue of their continuing endorsement of consumer demands and their own continuing activities outside of work on citizens' committees and organizations. They have experience in being responsible to citizens' boards and feel that they are dependent upon these bodies for their jobs -- either directly as board members of the agency for which they work, or indirectly as an interest group which helps to keep the program funded.

The changing political complexion of physicians' and other medical associations were outlined in a 1967 article by Elinor Langer, entitled "AMA: Some Doctors Are in Revolt, But Revolution is Not in Sight."[20] The revolution over control of health services and facilities is much closer to happening now in 1970 than a few years previously. It is expressed and sustained in part by the rapidly changing structure of organizations and associations of health care professionals. One of these groups, the Medical Committee for Human Rights, was established to give medical assistance to civil rights workers and has evolved into a group advocating broad changes in the health care system. MCHR has

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[20]Elinor Langer, "A.M.A.: Some Doctors Are in Revolt, but Revolution is Not in Sight," Science, Vol. 157, No. 3786 (July 1967), pp. 285-288.

expressed solid support for the goal of community control of health care services and facilities. The organization's president in a letter to the membership asked "Should we relate to consumers and hospital workers by encouraging their membership in MCHR, or by supporting their struggles...?"[21] MCHR has been confronting the AMA House of Delegates meetings in various forms annually since 1965. MCHR wrote the AMA before its 1970 House of Delegates Convention to demand that it "hear firsthand of the American health disgrace and AMA's responsibility for it."[22] The AMA responded by offering to hear consumers at a committee meeting and hired guards to protect the House of Delegates sessions. Consumer groups including the National Consumer Health Committee and the National Welfare Rights organization took over the committee meeting and voiced their demands. The demands voiced by these groups were not so much about community control, but were a direct expression of it -- consumer representatives behaving as a pressure group trying to influence the content of medical policy. They called upon the AMA to reverse its opposition to national compulsory health insurance, for example.[23]

A new generation of doctors is currently giving new meaning

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[21] Eli C. Messinger, National Chairman, MCHR, Letter to membership, Sept. 10, 1970.

[22] "Health Rights News," August 1970, p. 2.

[23] Ibid., p. 2.

to Virchow's famous quote: "The physicians are the natural advocates for the poor." In major cities across the country, medical students and young doctors have organized themselves around issues of reform of the current health care systems. A major thrust of their organizing efforts to date has been to press for faster improvement in the quality of care for poor, disadvantaged groups. A corollary of this general interest has been support for more extensive consumer participation in determining the scope and form of health care programs and endorsement of community control measures in some cities.

The changing posture of some medical professionals is illustrated by the evolution of the Student Health Organization, established in 1965 as an alternative to the more conservative Student American Medical Association. SHO started out with a strong orientation toward service projects. They sponsored an impressive array of summer service projects in the first three years of their existence. Lately the members of the group have shifted their emphasis to direct political actions aimed at radical change in health care. SHO has ceased to function actively as a national group. A growing number of students in the health sciences are working on local political activities.

Often the opposition of established health care agencies and institutions has been directed at proposals for the creation of neighborhood health centers rather than at the provisions for consumer participation or community control which are a part of

those proposals. The disagreements about the neighborhood health center as a new way of delivering health care overlap with the debate over the relative merits of consumer participation and community control. Some specific arguments against the neighborhood centers translate directly into objections about consumer involvement or control. Others relate to it more subtly or not at all.

OPPONENTS OF GREATER CONSUMER PARTICIPATION

Doctors have viewed the new centers as a "new outbreak of Government medicine."[24] Other common complaints are that the centers are a product of insufficient planning, that they provide inadequate roles for local health departments, and are susceptible to "political exploitation."[25]

The OEO legislation requires that the neighborhood health programs make maximum use of existing agencies and resources and private enterprise. This dictum has not been followed to the letter, and existing agencies and private purveyors of health care have been consistent opponents of the establishment of the neighborhood health centers. The standard form of expression of

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[24] Charles Walter, "Anti-poverty Medicine: Another Big Sleep," Medical Economics (Nov. 14, 1966), p. 74.

[25] Ibid., p. 84.

this opposition is the concention that the new program has failed to consult meaningfully with these relevant groups.[26] Local Medical Societies decry the failure of neighborhood health center planners to invite them to be a part of the process. They warn that the new vehicles will be uneconomical and will suffer from shortages of trained staff.

Where physicians maintain private practices in or near the district to be served by a center, they are often fearful that it will draw away some of their patients. With regard to this source of opposition, Medicaid cuts as a double-edged sword. One blade holds the prospect of supplying a steady fraction of the budget of a neighborhood health program. However, the other works against innovation by improving the lot of physicians who prefer to work in traditional patterns and see their ability to do so enhanced by the availability of Medicaid payments.[27] The current variety of organizational relationships and the tremendous fragmentation of medical responsibility leads physicians to look to their medical colleagues rather than client controls.[28]

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[26]Eric Bishop and Hal M. Christensen, "Dentists and the War on Poverty: A Discussion of Neighborhood Health Centers," Journal of the American Dental Association, 75: 45-54.

[27]Donald Madison, op. cit., pp. 793-4.

[28]Eliot Friedson, "The Organization of Medical Practice," in Howard E. Freeman, Sol Levine and Leo G. Reeder (eds.), Handbook of Medical Sociology (Englewood Cliffs, N.J.: Prentice-Hall, 1963), p. 303.

It will be noted that many of these objections do not relate specifically to consumer participation or control. The institutional form which they object to, however, is in part a product of consumer involvement. Consumers have been active in helping to plan these new facilities and their concerns are embedded in the proposals made and implemented. Usually, the health professionals get around to objecting to participation only secondarily. The AMA's history of opposition to even the mildest and most constructive of official intrusions into the field has been thoroughly reported. The profession has profitted from the political potential of its members' continual contact with patients and the trusting nature of that relationship.[29]

Other anti-poverty program employees have been important opponents of the demand for greater consumer participation. Although they may be, or have been, "of the poor", they have acquired professional values and loyalties. They realize that in many cases they perform tasks which consumer representatives have in the past helped to accomplish and could still handle in their absence. They see movement toward community control as a threat to their jobs if they have civil service status.

Health professionals interested in reforms or innovations come at issues of consumer participation from both sides. The professionally-oriented reformers tend to view consumer involvement

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[29]Richard Harris, A Sacred Trust (New York: New American Library, 1966).

as an unnecessary distraction and a waste of time. Consumer-oriented reformers see consumer participation as a source of support for the changes they propose, but sometimes the goals embodied in those changes conflict with the requirements or consequences of participation.

A strong movement for reform of the health care system focuses on the development of comprehensive and coordinated systems. These plans often include ambulatory care units similar in scale and in scope of services to the neighborhood health centers, but with little or no provision for consumer participation. They are typically drawn up with little or no consultation with representatives of low-income patient populations. An excellent example of this direction of reform is the plan announced last year in Boston for state-sponsored ambulatory clinics. This approach to reform of the health system seeks to take out of the hospital setting those functions which the hospitals do not want to perform and do poorly: dispensing first aid, preventive medicine, health education and health evaluation. Dr. Leonard Chronkite, architect of the plan and president of the new organization charged with implementing it, Health, Inc., disdains consumer participation and disparages much of the work of paraprofessionals in health as "fluff." His scheme is a tight, comprehensive and carefully coordinated approach. It was greeted by considerable adverse reaction by neighborhood health consumer groups in Boston.

A team of Nader's Raiders has proposed the formation of a government agency, the National Board of Medicine, to enforce

tougher medical standards. The proposal criticizes AMA "peer review" efforts as a means of avoiding meeting the problem. It advocates more strigent licensing requirements, standardizing patient record forms, and so forth.[30] This thoroughly professionally-oriented approach to quality control contrasts sharply with the ideals of consumer representation where consumers serve as watch-dogs and through influence or authority enforce standards of care. Perhaps this is the ultimate governmental response to be expected from most demands for community control: health care authority will be taken away from private hands and vested in government bureaucracies, or taken away from municipal departments of health and hospitals and vested in public-private corporations. An assumption of most of these proposals is that they will inaugurate a form of health care and a quality of care satisfactory enough to render unnecessary any substantial consumer involvement.

A recent American Hospitals Association proposal declared that health care is "an inherent legal right of each individual of the United States." The report proposes the regrouping of doctors and hospitals into scores of "health care corporations." It affirms that health care should enhance the dignity of the individual and promote better community life, that it should be available without regard to ability to pay or to race, creed, color, sex or

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[30] Washington Post, Nov. 9, 1970, p. 42.

age, and accessible to all.[31] These objectives are approached by the neighborhood health center and are protected through consumer participation in them. However, the listing of these principles in this context indicates that there are other approaches to attempting to meet these same goals.

Sometimes health professionals' support for consumer participation conflicts with other objectives they hold for the centers. For instance, health professionals have been quite open about their interest in neighborhood health centers as opportunities for research and for creating a new environment for medical teaching.[32] Count Gibson, a founder of the Columbia Point Health Center complained that medical schools are teaching hospital medicine although many students will be practicing community medicine. He feels that this is "like trying to train foresters in a lumber yard."[33] The Center provides a context for teaching community medicine. Extensive consumer participation or community control has tended to militate against the use of the centers for either teaching or research purposes. At the Columbia Point project, a research sub-

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[31] New York Times, November 24, 1970, p. 28.

[32] William F. Maloney, "The Tufts Comprehensive Community Health Action Program," Journal of the American Medical Association, Vol. 202, No. 5 (Oct. 30, 1967), pp. 411-414.

H. J. Geiger, "Tufts Comprehensive Community Health Action Report," Department of Preventive Medicine, Tufts University School of Medicine, August 1966, p. 1.

[33] Count D. Gibson, Jr., M.D., presentation to Harvard-Brandeis-M.I.T. seminar on "Urban Social Policy," Spring 1967.

committee of the consumers group, the Columbia Point Health Association, was eventually established to screen requests to do studies at the Center.

BENEFITS ANTICIPATED VS. LIMITATIONS CLAIMED

The supporters of greater consumer participation in planning and running neighborhood health centers claim that it:

(1) Improves program content, delivery and use;

(2) Benefits individual participants;

(3) Supports greater expenditures on health programs for the poor;

(4) Makes programs accountable to their clients;

(5) Fulfills democratic ideals;

(6) Reduces social and political alienation;

(7) Increases neighborhood integration and stability;

(8) Promotes the development of low-income interest groups;

(9) Equalizes the distribution of political power.

This list highlights the main contentions of those who demand greater participation and those who support that demand. Different persons and groups obviously stress different points, and may disagree with some of them, for the list includes contradictory goals and functions. Opponents of more substantial participation argue the converse of each of these propositions.

The benefits claimed for participation fail to separate -- as is the case in actual confrontations on these issues -- statements of goals for, and assumptions about, the effectiveness of the process

of consumer participation. Likewise, the counter claims are usually a complicated mixture of rejections of the goals inherent in the claims, and of objections to, or skepticism about, the capacity of mechanisms of participation to actually produce the intended results.

The listing and distinguishing of these functions -- intended and actual -- is hardly a casual exercise. But, the process of isolating the separate functions professed by citizen participation advocates and those which indeed are fulfilled by citizen participation helps to clarify an extremely muddled situation.

Persons advocating or opposing citizen participation often come to their positions with a host of unexpressed assumptions. These tangled orientations exercise a vital influence on the course of conflict over issues of resident involvement. Resolution of the conflicts often hinges on the discovery, in a particular situation, of a capacity to identify the whole range of assumptions involved and to deal with some of them in new ways.

Disputants in this area frequently puzzle each other over what they are arguing about. The term "consumer participation" carries with it so vast a range of intended functions, appropriate approaches and organizational arrangement, that its usefulness as a term of discourse is limited. Sometimes its primary function is to serve as a tattered banner carried into battle on these issues.

Persons who voice the professional exhortations on consumer participation emphasize benefits in these areas. Many of the other claims, listed above, are less explicitly or regularly discussed by the contending parties in these disputes. Some are

mentioned only in conversation or in the heat of accusatory meetings. Many of all are extensions of objectives and functions attributed to Community Action programs, community mobilization and participation efforts, and to other social services. The list provides a set of possible dimensions of comparison of the potentialities and limitations of consumer participation and control that exist in health and in other functional areas.

1. Improves program content, delivery and use

Its supporters claim that health consumers are in a privileged position in terms of their knowledge about the programs offered to them. They can suggest new approaches and advise on policies which will make neighborhood health programs more accessible and more attractive to potential patients. Their ideas can improve the quality of care rendered.

Dr. Joseph English, formerly a federal administrator with responsibilities for neighborhood health centers at both HEW and OEO, states this conviction:

> I think a fiction has been perpetrated that the poor do not know what good medicine is. The people I've listened to have been expert in describing what they consider good family care. And the reason they are experts is because for 20 or 25 years they've known what it's like not to have it.[34]

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[34] "For Those Who Need It Most," Medical World News (March 8, 1968), p. 47.

A study of health care in a lower Manhattan district concluded that when residents were asked what type of care they desired, their answers "when taken in the aggregate, reveal a surprisingly well-focused critique of current facilities...."[35]

Participation is promoted as a route to furthering residents' health education -- in learning good health habits, when to seek medical treatment, and how to follow physicians' instructions. This learning is transmitted through consumer representatives and is encouraged by the creation of a greater awareness of and interest in health matters as a result of community identification with the neighborhood health facility.

The report of a national advisory commission noted that success in improving the quality of health care

> will require a citizenry that is sufficiently well informed and motivated to follow established principles conducive to good health and to cooperate fully with health services in all phases of preventive treatment of illness and disability.[36]

Residents' utilization of health services is said to be increased and patterns of use made more medically appropriate through consumer participation and control. These effects are achieved by reducing patients' mistrust of health professionals and reducing their alienation from health agencies and institutions.

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[35]Walter Thabit, Health Services in Cooper Square (New York, November 1966), p. 9.

[36]National Commission on Community Health Services, Health is a Community Affair (Cambridge, Mass.: Harvard University Press, 1966), p. 17.

A series of discrete steps are involved in obtaining medical care. Middle and upper class patients tend to conceive of these as one single motion because they experience relatively little difficulty with the process. It actually includes: (1) deciding that one needs medical assistance, (2) deciding to seek medical assistance from a physician, (3) finding a physician or a health service that is accessible, within one's means, etc., (4) cooperating with the history-taking and physical examination, (5) listening to diagnosis and the prescription of treatment, and (6) cooperating with the doctor's instructions and orders. Only one of these six steps is a purely medical function.[37] In light of this fact, the non-medical aspects of health care become extremely important. Consumer involvement is seen as a path to easing these steps.

> A problem as critical as knowing how to treat illness is knowing how to attract patients, encourage them to cooperate with the procedures necessary for diagnosis, and get them to follow the prescriptions of professional workers.
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> Utilization will not be optimal and cooperation will not be all it can be when the patient feels helpless and at the mercy of professional judgment and interest.[38]

A host of studies have shown that lower class persons are more likely to delay seeking treatment for illness. Utilization is lower

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[37] Eliot Friedson, Patients' Views of Medical Practice, (New York: Russell Sage Foundation, 1961), p. 9

[38] Ibid., p. 228.

for groups which are more skeptical of doctors and their abilities and which are "ethnically exclusive," a sociological euphemism for ghetto-dwellers. Utilization rates are higher for groups ranking high on a scale of cosmopolitanism and lower for those at the "parochial" end of the scale.[39]

Anecdotal examples abound of the contributions of consumer representatives and paraprofessionals which dramatize the low-income health consumers' expertise. These colorful stories usually relate to rather marginal, but symbolically important aspects of service. For instance, the consumer representatives have chosen furnishings and wall colors which health providers would have done differently.

Consumer participation has been a major vehicle for broadening the concepts of disease beyond the set of physical and mental ills dealt with in medical school textbooks. Consumer participants and neighborhood health center supporters voice concern over the healthfulness of the living environment. Supporters of consumer participation in the neighborhood health centers see them as instruments for insuring that physicians will treat the "whole man," that health care will take into consideration the social and environmental factors in the lives of these patients. A primary goal of activities of the centers is to treat individual

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[39]Rodney M. Coe and Albert F. Wessen, "Social-Psychological Factors Influencing the Use of Community Health Resources," American Journal of Public Health, Vol. 55, No. 7 (July 1965), pp. 1025-26.

patients and their families. However, the theoretical thrust of the program and the expressed interests of consumer participants have resulted in more than just lip service in treating the total community.

High on consumers' priorities nationwide have been 24-hour emergency service and dental care.[40] Consumer involvement has contributed to a greater emphasis on supplementary programs such as nutrition, health education and family counselling.

Physicians are more likely to understand the environmental factors in their patients' ailments and attitudes toward medical care, through consumer participation. Dr. Harold B. Wise, Director of the Montefiore Neighborhood Medical Care Demonstration, comments:

> It's like learning another language. Once you've learned to think in French, you speak French well. Well, I'd been taught to think technically. For instance, when I see a man with an ulcer, I think of an X-ray picture of the lesion. The two are simultaneous projections in my brain. But until recently I didn't also project the fact that his wife is pregnant, his boy isn't doing well in school, and he lives in a crowded apartment. I have to make all such information part of the way I practice medicine if I'm going to help my patients.[41]

Some standard medical procedures are felt by lower class patients to be invasions of their privacy. They are a "direct

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[40] Bishop and Christensen, op. cit., p. 51.

[41] Harold B. Wise, "Montefiore Hospital Neighborhood Medical Care Demonstration: A Case Study," Millbank Memorial Fund Quarterly, Vol. 46, No. 3 (July 1968), Part I, p. 92.

assault on a person's conception of himself."[42] These patients tend to avoid situations in which they occupy this disadvantaged position. It is argued that consumer participants can help to make medical personnel sensitive to these difficulties and perhaps stimulate ways of changing the procedures or accomplishing them in new ways. In addition, consumer involvement may help residents to understand the need for these procedures and learn to accept them more readily.

Consumer involvement can be a vehicle for spanning or narrowing the "cultural space" which exists between professionals and patients and which is a real barrier to improved health care. This cultural distance derives from vastly disparate levels of general education and existence in widely different cultural surroundings, and it is expressed in mutually confusing jargon and mannerisms.

Sir Geoffrey Vickers has remarked that the history of public health could be written in terms of the successive redefining of the unacceptable.[43] Consumer participation contributes directly to this process of redefining the unacceptable. It changes and expresses consumer demands for health care. It can make more politically viable those institutional changes which

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[42] Coe and Wessen, op. cit., p. 1029.

[43] Theodore M. Berry, "Recent Federal Legislation: Its Meaning for Public Health," American Journal of Public Health, Vol. 56, No. 4 (April 1966), p. 585.

it supports. Thus, consumer participation may be seen as a route to modification of the public interest, to making the poor regular contributors to the ongoing calculus by which we figure that elusive commodity. Bernard Frieden comments with regard to the egalitarian ideals which stimulate social planning, "When these values are taken seriously as a basis for public action, it will no longer be necessary to legitimize programs of social reform as an expression of private interests advanced through advocacy on behalf of the poor."[44] Consumer participation is a form of advocacy of group self-interests.

Those opposing the arguments outlined above charge that the poor do not really know what they want, and that their notions about their own health needs and how they should be met are fallacious. Consumer participation results in less productive concepts of health care, and encourages an emphasis on programs and approaches peripheral to central health care needs. It injects undesirable priorities into a neighborhood health program. The poor evidence some inclination in the direction of preference for categorical programs. The basis of their focus on specific problem areas is the urgency and visibility of these problems. These characteristics are essentially the same ones which have

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[44]Bernard J. Frieden, "The Changing Prospects for Social Planning," Journal of the American Institute of Planners, Vol. 33, No. 5 (Sept. 1967), p. 314.

historically provided the pressure and rationale for the mounting of categorical programs at the federal level.

> In looking at the model cities health plans, it is not difficult to tell when a group of citizens actually participated in the planning, or when it was turned over entirely to the local health department. The residents' priorities in large cities are too often medical care programs or programs to meet the most visible health problems in the slums such as rats, narcotics, and alcoholism.
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> On the other hand, when the health department has had the major input into the planning, the plan is likely to be similar to the organization of the health department with recommendations for expansion of well baby clinics, chronic disease programs, and even laboratories.[45]

It is argued further that the energies devoted to consumer participation and the conflicts fostered by participation decrease program accomplishments on other goals and increase the time necessary to reach these goals.[46]

There has been considerable skepticism about the contributions low-income residents can make to a planning process.

> Political and protest organizations have proven effective in calling attention to inequity and have often succeeded in halting action which does not conform to minority group interests. They have been less successful in devising constructive solutions for the problems of the cities which rise above a simple

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[45] Donald Madison, op. cit., p. 793.

[46] Ibid., 787. The most forceful argument of this point is made with regard to urban renewal by James Q. Wilson, "Planning and Politics: Citizen Participation in Urban Renewal," Journal of the American Institute of Planners, Vol. 29, No. 4 (Nov. 1963), pp. 242-249.

> negative veto of someone else's plans. Once the disadvantaged have made a place for themselves at any negotiating or planning table, what will they contribute to the plans? What kinds of technical competence will they have to develop or acquire?[47]

Another type of objection to consumer participation is directed at the decisions influenced by the process of that participation. Some opponents of resident involvement in planning and running programs point to the resultant impacts on the programs or other facets of life. This line of argument does not take issue with control *per se*, but with the negative accomplishments of controlling groups of neighborhoods or districts. A good example of a consumers group with power which has tried to deny to others the benefits they are enjoying themselves is the Columbia Point Health Association, which resisted pressures from OEO to expand the patient population covered by the neighborhood health center to include persons living in another public housing project.

2. Benefits individual participants

Participation can provide socio-therapy for the consumer representatives involved, according to supporters of the concept. The process of participation can fulfill the requisites of positive mental health as defined by the degree to which a person realizes his potentialities through action, the individual's degree of

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[47]Bernard J. Frieden and Robert Morris (eds.), Urban Planning and Social Policy (New York: Basic Books, 1968), p. 180.

independence of social influences, or one's ability to take life as it comes and master it.[48] Participation advocates point out that it strengthens participants' sense of dignity and personal worth.

> The person who of his own free will decides to work on behalf of the good of his community is in effect saying: "I have gifts and talents which are needed. I am a person who accepts a responsibility, not because it is imposed upon me, but rather because I wish to be useful. My right to be thus used is a symbol of my personal dignity and worth.[49]

Citizen participation has taught those residents who are involved political and organizational skills and discipline. An evaluation of the organization which ushered Saul Alinsky into the community organizing Hall of Fame states that "what makes the Woodlawn Organization so significant is not so much what it is doing _for_ its members as what it is doing _to_ them."[50]

Individual participants acquire skills in leadership, in functioning in work settings, in taking roles essential to the functioning of effective, successful interest groups.

Participation increases the incomes of those involved if they receive payment for attending meetings and other work. It

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[48]Marie Jahoda, _Current Concepts of Positive Mental Health_ (New York: Basic Books, 1958), p. xi.

[49]Edward C. Lindeman quoted by Nathan E. Cohen in "Citizen Participation the Backbone of Democracy," in Nathan E. Cohen (ed.), _The Citizen Volunteer: His Responsibility, Role and Opportunity in Modern Society_ (New York: Harper and Bros., 1960), p.33.

[50]Charles E. Silberman, "Up from Apathy: The Woodlawn Experiment," in Frieden and Morris, _op. cit._, p. 195.

can be an effective base from which to find jobs in neighborhood health and related programs.

Frank Riessman has stated that individual psychological problems diminish as a consequence of involvement "in some larger commitment or activity of social movement."[51]

Holding income constant, it has been found that

> persons in a neighborhood become involved in successful social action on important issues, in their own behalf, their psychological orientation does extend over a greater period of time, their feeling of helplessness does lessen, their skills and activities do gradually change.[52]

Opponents of more substantial participation stress the fact that it is tremendously expensive in time and personal energy, and dwell upon the danger that it can be a bitterly disappointing experience if all the hard work does not lead to concrete and satisfactory results.

3. Supports greater expenditures on health programs for the poor

Consumer participation can help to correct imbalances in the allocation of resources for health services. This objective is

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[51]Frank Riessman, "New Models of Treatment of Low Income Groups, Trans-action, Vol. 1, No. 1 (Jan. 1964), p. 8.

[52]Warren C. Haggerstrom, "The Poor of the Poor," in Frank Riessman, Jerome Cohen and Arthur Pearl (eds.), Mental Health of the Poor: New Treatment Approaches for Low Income People (New York: The Free Press, 1964), p. 208.

achieved through the political pressure amassed behind proposals for government programs to redress current inequities in the distribution of funds and manpower in medicine. As one example, consumer participation in the aggregate may build support for such efforts as the attempts to amend the Hill-Burton Act to permit funds to be used for the construction of free-standing clinics in urban areas.

The counter-argument, of course, is that participation skews the allocation of resources away from the desirable. It adds muscle to efforts at shifting resource allocation in directions which are ill-advised. It makes for misallocation of resources locally by funnelling money into only one or a few of the many low-income neighborhoods in a city and leaving the others with no improvement.

4. Makes programs accountable to their clients

> We are confronted today with the difficult task of renegotiating the complex social contract between the public and the medical profession so that an acceptable compromise can be found between the advantages of free enterprise and the demand for public accountability.[53]

Consumer participation sustains the demand for public accountability and gives it a form of institutional expression:

> Involvement of the poor will mean that what once were closed systems where the poor were subject to the whims and arbitrary decisions

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[53] Kerr L. White, "Personal Incentives, Professional Standards, and Public Accountability for Health Care," Hospitals, (July 16, 1968), p. 79.

> of authorities will become ventilated. Decisions never before visible will be seen. The assumptions on which decisions are based will be revealed -- and questioned. And demands for consistency, fair play, and equality of treatment in every sense will begin to come from the poor themselves, operating from within -- not outside -- the system.[54]

The administrative guidelines for the neighborhood health center programs clearly imply that existing governmental arrangements do not satisfactorily provide for public accountability in medicine. The increasing governmental share in financing health care is accompanied by enhanced governmental control over the functioning of the sector. However, the mechanisms by which we operate a pluralistic, democratic body politic fail to make the health system sufficiently responsive to public demands. Why is it that the option of "voting the scoundrels out" is relatively inappropriate in the health field? Health issues rank lower in political priority among citizens. Housing, education, employment, public safety and other concerns consistently outdistance health in public opinion surveys taken in low-income as well as better-off areas. Hence, the grounds upon which persons cast their votes on candidates for public office may include their positions on health issues, but these are likely to be a minor ingredient

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[54]Lisbeth Bamberger, "Project Planning and Development of Official Health Agencies, I. Opportunities for Official Health Agencies in the Community Action Program," American Journal of Public Health, Vol. 56, No. 4 (April 1966), p. 597.

in voters' choices.[55]

A second important reason why our regular channels of representation do not satisfactorily represent health concerns is the lack of "good fit" between the institutions and programs in the health fields and the governmental mechanisms that increasingly control their financial well-being and other aspects of their existence. The question is one of scale and the intricacies of local government. There is representation at the national and state levels which reflects the views of various health provider and consumer groups. Locally, however, the constituencies of health agencies, institutions and programs jibe poorly with the relevant political jurisdictions. Furthermore, the sources of support of these health operations are vertically scattered among layers of government and horizontally among local geographically centered units of control. A neighborhood health center, by necessity, relates to a variety of provider and consumer interest groups. Each of these groups has only an indirect line

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[55]Certainly there are exceptions to this general situation. Health issues do on occasion blossom into severe crises which crystallize a level of public interest that make them hotly contested items in an election campaign. A primary example of such crises is the recent financial difficulties of municipal hospitals, fanned by well publicized exposés of shabby physical conditions in these institutions. The rising degree of public concern over health care costs can make that issue (and related points of organization of delivery and administration) an important feature of campaign rhetoric and a major hinge of confrontation in the governmental arena.

of communication with and effective pressure over the funding agency. Ultimately, of course, the members of the interest groups have their individual votes for area representatives in Washington.

Most local public health departments have a semblance of public accountability through the fact that the manager of the department and members of the board are appointed by the mayor, who is elected by the people. The accountability is obviously indirect, and membership on most department board of directors is for staggered terms.

The Health Task Force of the Urban Coalition reported in November 1969 that the boards of directors of most voluntary agencies, municipal advisory groups and similar groups "are composed primarily of persons of substantial wealth or representatives of large businesses."[56] The report noted that recently representatives of labor and of minority reports have been included on these boards, but the middle class remains "almost completely eliminated."

Opponents of consumer participation in decisions about health programs reply that sufficient public accountability already exists. Too much accountability politicizes health care with disastrous effects on the structure of the system and on the quality of care delivered. Critics of the accountability argument question whether consumer participation will in fact have the effects assumed above. They predict that the ultimate result of adding

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[56] New York Times, Nov. 23, 1969, p. 54.

more groups to an already complicated set of influences will be to hopelessly muddle the public accountability of health programs and agencies.

5. Fulfills democratic ideals

Proponents of participation and community control in health cite them as basic procedures of governance which have been denied low-income persons to date and which must be established if we are to fulfill our democratic ideals. Those on the other side feel that participation and control are actually anti-libertarian -- that they strengthen some local groups at the expense of others and overload the capacities of our representative system, with regard to health, by forcing upon it a new layer of advocates.

It has been argued that citizen participation undermines the democratic processes and institutions which already exist. U.S. mayors argued that the CAP requirement of maximum feasible participation attempted to establish a dual system of government, partially supplanting the one already in existence which they headed, as duly elected public representatives. One observer charged that citizen participation efforts and community organization efforts in general were undesirable because they serve "to make a gross, and frequently unjustifiable distinction between the urban dweller and his government and his institutions."[57]

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[57] Roger Starr, The Living End - The City and Its Critics (New York: Coward-McCann, 1966), p. 51.

6. Reduces social and political alienation

Consumer participation is credited with being a means of maintaining social order locally by permitting a broader sharing of political influence, by encouraging groups to feel an investment in and commitment to the health programs in question. Alienation from these health programs and from social and political institutions generally will be reduced by granting low-income communities greater control over these institutions. A neighborhood health center can be a visible symbol of governmental caring or presence and of neighborhood-focussed activity.

The contrary position holds that participation may in fact increase alienation when the consumer involvement does not yield results, and produces another example of unfulfilled citizen expectations and unkept government promises. In addition, mechanisms of consumer participation and control circumvent existing organizational channels of citizen representation in health issues.

For the missionaries, providing medical care was a means of gaining the natives' acceptance. It was not only a service, but also an entrée to, a basis for proselytizing the natives to a particular religious faith. The colonial metaphor as applied today charges the same motivation -- that the federal government's provision of health care is founded on a desire to keep the hatives happy.

Community control may lead to greater racial separatism by encouraging the development of neighborhood health facilities that serve only a black or a white community and have inadequate links

with other health agencies with whom working relationships are required. A great many of the neighborhood health centers are located in predominantly black and other minority group residential areas. This is bound to cause some resentment on the part of lower-income whites, who comprise a sizable portion of the medically indigent population nationally.

7. Increases neighborhood integration and stability

> Public health, or the sufficiency of health services, can and has turned geographically separated aggregates of individuals of the same race or of the same social condition into communities.[58]

Another discussion refers to the neighborhood health center as a "tangible symbol of this new level of social cohesion."[59]

Consumer participation in neighborhood health centers has been urged as a way of improving the image of the black male in poverty areas. A report of the South Central Multipurpose Health Service Center recommended that two-thirds of the Center's Community Health Council "be mandatorily male," because otherwise women would dominate the group. The two-thirds provision was intended to help to establish "meaningful male models."[60]

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[58] Rona M. Fields, "The Politics of Community Mental Health," Social Policy (September/October 1970), p. 57.

[59] Eric Bishop and Hal Christenen, op. cit., p. 48.

[60] Jack Elinson and Conrad E. A. Herr, "A Sociomedical View of Neighborhood Health Centers," Medical Care, Vol. 8, No. 2 (March-April 1970), p. 99.

The Alviso, California health center was conceived by an Anglo labor organizer operating with the explicit aim of building solidarity among the Chicano farm workers. The project began when he was "casting about for an appealing adhesive force."[61]

For major institutions, the establishment or sponsorship of a neighborhood health center can be a means of trying to alter the character of the immediately surrounding neighborhood. It has been argued that this was a primary motivation behind development of the Temple University-affiliated center and the one started by Mt. Sinai Hospital and Sears, Roebuck & Co. in Chicago.[62]

On the other hand, consumer participation or community control can provide a context for open warfare between different groups in a neighborhood, each of whom desires to control the new health center. This result is a real danger since the centers often represent a substantial prize because of their potential as a power base and because they are the source of sought-after new jobs. Many of the areas where neighborhood health centers are located are not homogeneous districts. They include groups with divergent health needs and political orientations. The prospect of consumer participation or control may have the effect of exacerbating these intra-neighborhood conflicts.

A common criticism of consumer participation is that it has been used to, or has had the effect of, enervating or under-

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[61] Ibid.

[62] Ibid., pp. 100-101

cutting emerging indigenous leadership.[63] Neighborhood leaders are effectively coopted by giving them jobs with the program or positions of influence and authority as consumer representatives to the program. Both roles require an orientation at odds with the requisites of protest leadership. The tasks demanded by these roles and the attitudes which they imply, it is argued, conflict with the needs of developing leadership at the neighborhood level. These new positions and roles in programs remove the individuals from situations in which they stood to learn more or to be more effective agents of change on the same set of issues. The original OEO guidelines for the CAPs were sensitive to these dangers and attempted to encourage structures which would minimize them. OEO personnel were concerned that citizen representatives employed by the CAPs would lose truch with their neighbors as they acquired the working habits and attitudes and goals of their more professional colleagues in their new work situation. The fear was that these neighborhood persons would drift toward the professional middle class and away from those incipient organizations which they were formerly of and were expected to represent.[64]

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[63] Jean C. and Edgar S. Cahn, "The War on Poverty: A Civilian Perspective," Yale Law Journal, Vol. 73, No. 8 (July 1964), pp. 1315-1352.

[64] Community Action Program, Office of Economic Opportunity, Community Action Program Guide, Vol. I, Washington, D.C., 1965.

8. Promotes the development of low-income interest groups

The poor are said to lack the essential characteristics of an interest group with effective access to the institutions of government: command of substantial economic and social resources, extensive interaction among members, a supply of experienced leaders, a deep commitment to a clear and conservative set of objectives, and sufficient prestige in the larger society.[65] Consumer participation can be a means to supplying these lacking characteristics. It can provide social resources and some economic ones as well if the consumer representatives group are given a budget of their own. The meetings of consumer representatives make more for frequent and intensive interaction among members, and create the conditions necessary for the emergence and development of local leaders. The process provides a context for hammering out and communicating objectives. Association with an innovative new institution of merit in the eyes of outside groups, and receiving some initial publicity locally, is a route to enhanced prestige in the larger society. Consumer participation and community control can be a vehicle for creating viable new interest groups around issues of health care and related interests.

The establishment of neighborhood health services can be an instrument for the politicization of patients. For instance, the

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[65] David Truman, The Governmental Process (New York: Knopf, 1951), pp. 265-270.

three-room trailer clinic affiliated with Judson Memorial Church serves lower East Side youths and publicizes the "10 Point Program of the Health Revolutionary Unity Movement."[66]

Health professionals may find it in their own interests to encourage the emergence of strong neighborhood health councils and boards.

> It is increasingly evident that the passive rejection of health services by avoiding, or by dropping out of treatment will be replaced by organized sit-ins at neighborhood clinics or at the offices of health planning organizations. Health planners will want to utilize and seize upon these and other forces as leverage against medical resistance to the implementation of their plans.[67]

On the other side of this question, it is argued that consumer participation (if not community control as well) undercuts the development of indigenous leaders and coopts incipient political protests. Both of these effects retard the development of neighborhood community organizations mobilizing around health issues. In addition, participation and control, as noted earlier, may promote conflicts within a low-income area and therefore operate as a divisive force which negates any chance that a local interest group will develop to its full potential.

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[66] Elinson and Herr, op. cit., pp. 101-102.

[67] William W. Nash, Jr., "An Overview: Forging Effective Links Between Health Service and Facility Planning, and City and Regional Planning," in Planning for Health Services and Its Relation to City and Regional Planning Activities (Cambridge, Mass.: Joint Center for Urban Studies of Harvard and M.I.T., 1968), p. B-74.

9. Equalizes the distribution of political power

Consumer participation and community control have the effect of taking power away from established medical agencies and institutions and placing it in the hands of local consumer groups. Giving consumer representatives authority over elements of policy at a neighborhood health center not only challenges the authority of the health agencies with which the center does business, but it also provides consumers with a base from which to exercise political influence more broadly in health affairs.

Skeptics on this point contend that political power is not redistributed; instead, the total fund of power is expanded somewhat and the powers of established medical institutions left intact. As a result of consumer participation being focussed on small neighborhood facilities, the larger health institutions which operate city-wide are relieved of pressures for change and maintain their previous suzerainty. An alternative line of argument against the claimed benefit of redistribution of power accepts the reality of that result, but anticipates abuses of power by the consumer groups and decries those abuses.

At the neighborhood level, intra-community structures of influence may be skewed by consumer participation. A survey of ten neighborhood health programs concluded that moderate viewpoints tend to be under-represented in comparison with the interests of militants, business and professional groups and social agencies. The same study documented tendencies toward authoritarianism both on

the part of providers and consumer groups.[68]

[68]Goldberg, Trowbridge and Buxbaum, op. cit., p. 38.

CHAPTER II - DEFINITIONS AND THEORETICAL CONCEPTS

DEFINITIONS

A nearly universal problem in the academic literature on consumer participation and in popular use of that phrase and related concepts is that they are used so imprecisely that chances for productive discussion are precluded. Persons and groups engaged in debate over issues of consumer participation attempt to communicate using terms to which they attach vastly different meanings.[1] Academic treatment of the same issues has failed to build a coherent body of theory on the subject in part because practitioners of the art refuse to define clearly their terms or to specify their assumptions. As a result, conflicting and sustaining evidence is gathered and presented, and the work of different researchers does not feed into a common struggle toward understanding.[2]

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[1]G. M. Hochman, "Consumer Participation in Health Planning: Toward Conceptual Clarification," American Journal of Public Health, Vol. 59, No. 9, (Sept. 1969), p. 1698.

[2]This controversy is not solely an instance of lack of clear and adequate communication, but one of conflict. A clearer understanding that the local medical society means advisory consultation by the term "consumer participation" in the city's application for a neighborhood health center or that a militant group within the target area construes it to mean substantial control over the operation of the center in no way lessens the degree to which their objectives are in conflict.

Hopefully, the pages which follow will justify the particular meanings presented below. For the moment, they serve as useful starting points. The definitions are intended more as a guide to the use of key concepts in this dissertation rather than as a statement of preferred general usage.

Power: The capability of acting or of producing an effect, of compelling others to go along with one's wishes or intentions. It is exercised through authority and influence, two distinct commodities and processes.[3]

Authority: Legal or formal power. Power exercised by a person or group by virtue of formal sanction, which is granted for a specific purpose and in a delineated frame of reference. This established, recognized right to power derives from formal, legal designation as expressed by law or recognized administrative codes or documents.

Influence: The holding and exercise of power which is not formally sanctioned, but exists outside of, or in addition to, authority. It is sustained and expressed through informal arrangements and interactions which are not legally designated, but which persist through time and exhibit regularities of behavior similar to those of authority.

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[3]This definition and those which follow draw heavily from the meanings articulated by Alan Altshuler in Community Control: The Black Demand for Participation in Large American Cities. (New York: Pegasus, 1970), pp. 62-65. The distinction between authority and influence is taken directly from his description.

Influence refers to the process or the power to produce an effect without relying upon legal right to support the exercise of one's will. It connotes the exertion of power as the result of conflicts among groups, often a gradual and insensible process. It acts without the exertion of tangible force and in the absence of any direct exercise of command.

The distinction between authority and influence is especially relevant to discussions of consumer participation and community control because the conflicts over appropriate amounts and locus of power (which extends the length of the spectrum from weak participation to firm control) are the guts of controversy in this field. As Altshuler notes, "The current crisis of political participation in American society is in part about the substantive distribution of power (who has it, with respect to what), but it is also about the legitimacy of specific participatory modes...."[4] Health consumer representatives who are demanding more power over neighborhood health programs seek to acquire and to exert greater influence and to have this power formally recognized as authority. Health providers who resist these demands maintain their exclusive hold on authority in this area and marshal their own sources of influence to protect that authority and to effect operating control.

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[4] Ibid., p. 63.

Citizen participation: The involvement of persons in planning and running of social services or facilities. The term implies not only taking part in an activity, but association with others in an ongoing relationship connected with that activity. It denotes a sharing of authority between persons served by a program or facility and those primarily responsible for providing services. It refers to the Community Action Program requirement of maximum feasible participation of residents of the areas and members of the groups served. Citizen participation makes no inherent exclusions as to who may participate on grounds of income, class, race, place of residence or program eligibility, however such restrictions are specified in practice. The process of citizen participation includes performance of a variety of tasks, designed to fulfill a series of functions or objectives. What constitutes an appropriate set of functions is a subject of vigorous debate. The concept is most commonly applied to the activities of formally designated advisory councils or policy-making boards, but can also refer to more informal modes of participation and to the employment of neighborhood persons by programs which serve their areas of residence.

Consumer participation: Involvement similar in all respects to that outlined for citizen participation, but restricted to activity by persons eligible for services from the program.

Consumer participation is a special case of the broader concept, citizen participation. Its narrower meaning indicates a more exclusive, more clearly delimited set of participants, and is

often connected with a categorical program rather than one less tied to a specific type of service. In addition, it denotes activity in government programs of more recent vintage. The term excludes not only area residents ineligible for services, but also professionals who are consumers.[5]

Consumer representative: An individual designated (by election, appointment or any other means) to participate in the planning and running of a program by conveying the desires and needs of his constituency -- the group which he represents, usually in a formal committee or council setting.

Community control: Manifest power over the operation of a program vested in a local body separate from the outside institution or broader organization which normally governs the operations of the program.

This power usually rests in arrangements of authority, but also derives from patterns of influence which are not formally recognized by statute or corporate form. Community control means that the locus of authority lies in a geographically defined unit whose residents are the ultimate source of the operating authority, which is usually expressed through democratic representa-

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[5]Consumers themselves tend to use a more parochial definition. A class on Health Consumers taught at the Boston University School of Social Work in the spring of 1970 polled students, many of them consumer representatives, for their definitions of "consumer participant." The consumers tended to restrict its meaning not only to non-professional consumers, but also to persons who are directly involved in trying to improve the quality of health care in their neighborhoods.

tion. Community control is distinguished from citizen or consumer participation by its indication of the greater extent of power residing locally.

Decentralization: The dispersion of authority over the conduct of a program, granting local neighborhood units or branches of a central administrative office a measure of community control over programs and facilities which they use.

Decentralization subsumes two processes, distinguished by Altshuler: (1) political decentralization, the dispersal of decision-making authority, the shifting of the locus of control over specific functions away from central dominance, and (2) administrative decentralization, which does not necessarily conflict with political decentralization, but often does.[6] Administrative decentralization means a location of operating authority from a central locus in the direction of more local groups, giving these units greater autonomy, but without any transfer of authority in a broader political sense. No shift is implied in the power relationship between the organization or institution in question and its clientele or its various constituencies. Obviously, the effective accomplishment of political decentralization may be dependent upon the implementation of some measure of administrative decentralization. This is necessary in some situations in order to facilitate local responsiveness, to insure the responsiveness of the organization to the new and expanded interventions, regularized

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[6]Altshuler, op. cit., p. 64.

interventions or involvement of its clients and constituencies. On the other hand, there are a range of current examples of administrative decentralization used, at least partially, as a substitute for political decentralization. A standard administrative response to popular demands for political decentralization is the administrative alternative.

A third set of meanings for decentralization has to do with the content of services or operations undertaken by the decentralized institution and the style of their delivery or administration. It might be argued that these questions are theoretically separable from issues of decentralization and ought to be logically isolated in this discussion. However, the salience of questions of the content and style of delivery of services are operationally inseparable in the minds, arguments and behavior of the groups most intimately involved with these issues. This is a particularly sticky point since the meanings attached to decentralization in this regard often are not made explicit. These components of definition appear most prominently as assumptions, as aspects taken for granted by the parties involved. The primary assumption is that decentralization means or implies certain rather specific changes in the mode of delivering services and what these services themselves consist of. The assumptions vary. It is assumed by professional proponents of decentralization of health services, for example, that decentralization means innovation: mounting programs for training paramedical personnel, closer working relationships with other social services, and so forth. Consumer

representatives who espouse decentralization and community control sometimes assume that the process augurs a shift back to more traditional, more personalized modes of health care - a return to the family physician form of practice, as opposed to team medicine. These assumptions cannot be separated from the questions of decentralization per se because they are a crucial part of what people mean when they talk about decentralization. A good deal of the conflict in this area revolves around these issues. The success or failure of decentralization in the administrative and political senses defined above may be determined by issues generated and sustained by conflicts over services content and style of services issues.

CONCEPTUAL UNDERPINNINGS

The research questions presented in the following chapters are grounded in theories of political power, the requisites of organizational maintenance and enhancement, and professionalism.

POLITICAL POWER AND INFLUENCE

Power is the basic currency of community control and participation. The best way to study it is by looking at controversies that display its exercise. The analysis of influence will focus upon decisions in the development of the neighborhood health centers, employing Dahl's definition of a decision as "a set of actions related to and including the choice of one alternative rather than

another."[7]

The conflicts about consumer participation and community control in health will be examined from the perspectives of systems of influence. The questions which follow in Chapter IV attempt to pinpoint which of the different modes of influence are most successfully employed in consumer involvement in neighborhood health programs. Banfield notes five basic processes through which influence works: (a) sense of obligation; (b) wish of the influencee to gratify the influencer; (c) rational persuasion; (d) changing the influencee's perception of the behavioral alternatives open to him, or his evaluation of the alternatives; and (e) changing the alternatives themselves.[8]

Dahl provides a more comprehensive list of the characteristics of bases or sources of influence: money and credit; control over jobs; control over information of others; social standing, knowledge and expertness; popularity, esteem, charisma; legality, constitutionality, officialty; ethnic solidarity; and the right to vote.[9] These specific sources of influence may be

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[7]Robert A. Dahl, "The Analysis of Influence in Local Communities," in Bernard Frieden and Robert Morris, Urban Planning and Social Policy (New York: Basic Books, 1969), p. 226.

[8]Edward C. Banfield, Political Influence (Glencoe, Ill.: The Free Press, 1961).

[9]Dahl, op. cit., p. 231.

categorized more economically as: inducement, coercion, rational persuasion, selling, friendship and authority.[10] The provisions for consumer participation in neighborhood health centers have varied in their emphasis on various of these bases and in the properties of the bases as well. The concept of differential access to these different sources of influence will be used to examine the participation conflicts in neighborhood health.

Students of political influence are careful to distinguish between the structure of influence and the process through which it is exercised. With regard to consumer participation in neighborhood health centers, this distinction implies that it will be important to look for differences and gaps between the formal structures of consumer participation and the actual functioning of participation within those structures.

In order for there to be effective consumer participation for whatever level of influence or set of functions, that participation must be organized. The obstacles to successful organization for participation are those which confront any attempt at community organization. These barriers limit the access of low-income groups and areas to political influence.

Michael Lipsky and Morris Lounds have outlined the obstacles which face community organization in general and which constrain

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[10]Robert Binstock, cited by Jeoffry B. Gordon, "The Politics of Community Medicine Projects: A Conflict Analysis," Medical Care, Vol. 7, No. 6 (Nov.-Dec. 1969), p. 420.

organization in the area of health affairs in particular.[11] A way of explaining current movements toward greater consumer participation in neighborhood health centers is to demonstrate that some of these obstacles have been removed or have diminished in size. Likewise, the future course of the conflicts surrounding issues of participation and control in health may be plotted by estimating the future strengths of these individual barriers.

The general obstacles include: (1) community hostility or cynicism toward political involvement, (2) lack of resources to sustain organization, (3) lack of leadership skills, (4) opponents' opportunities to coopt leadership and to induce modification of organizational goals. Factors which are special barriers to organizing participation in health are: (1) sporadic, rather than routine use of services, (2) perceived unresponsiveness of health institutions, (3) failure to view health as a community problem, (4) inequalities in health care being less visible than other discrepancies, (5) difficulties encountered in trying to identify a health community, (6) paucity and inadequacy of available pressure tactics, (7) legitimacy of the medical professions and the security of its expertise, and (8) high cost of health care services.[12]

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[11]Michael Lipsky and Morris Lounds, Jr., "Some Pathologies in Recent Social Planning Involving Citizen Participation: The Case of Health Services," paper prepared for the Symposium on Decision-Making and Control in Health Care, National Center for Health Services Research and Development, Rockville, Maryland (June, 1970).

[12]*Ibid.*, pp. 9-14.

Some of these obstacles have weakened over the past few years. The dearth of leadership skills has been overcome somewhat by virtue of local residents' experiences with the Community Action Programs and other community organization activities. Involvement in the CAPs provided opportunities for the development of leadership talent. In addition, it began to create constituencies for the leaders who emerged. These constituencies sometimes focussed around particular functional areas of service. Often, however, they were not entirely linked to a particular one, but constituted a group with general interests in improving the lot of a geographic area or a segment of the population. In a few cases, neighborhood health centers have given consumer representative groups financial resources of their own.[13]

With regard to the special difficulties confronting community organization in health, the recent publicity in national media about discrepancies in health conditions and the inadequacies of public programs and facilities is one factor that has changed the health picture to facilitate organization. The difficulties encountered in trying to identify a health community are reduced somewhat by the location of a neighborhood health center in a defined community. The pool of potential participants is defined by the boundaries of the area to be served by the center. The physical presence of a center in an area, or the prospect of

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[13]The Columbia Point Health Association, for example, has had its own budget which grew from under $5,000 in 1968 to almost $50,000 in 1970.

such a facility being established, helps to focus consumer interests and perhaps to assuage somewhat the felt unresponsiveness of health institutions. Cynicism and alienation from an outside health institution may be diminished by the fact of the district receiving its own center. This tangible, physical improvement helps to overcome to some extent the perceived unresponsiveness of the outside institutions involved with the neighborhood health program. The legitimacy of the medical profession is still high, but has been under increasing attack from within as well as without.[14] These challenges to the profession's legitimacy and all-encompassing expertise make it less able to brush aside attempts to secure greater consumer participation in health planning or to deny resources for the continued organization of health consumers and their representatives.

It is interesting to speculate on comparisons between issues of community control in health and in other fields of public service. Community control has been most hotly contested in education, and has stirred public controversy in the areas of police administration and other government operations, as well. What is so special about health? The distinctions are important to identify because discussion of the pros and cons of community control often

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[14] A November 1970 public opinion survey by Louis Harris found that 78% of the U.S. people agreed with the statement "I have a higher regard for my doctor than nearly anyone else I deal with," but documented widespread complaints about physicians' greed, reluctance to make house calls, etc. (Reported in the Washington Post, November 9, 1970.)

takes place without specific reference to specific service types or areas. In addition, the basic arguments and dilemmas are common to all fields although they may have developed primarily through debate surrounding a particular field of service.

The case of health care is particularly interesting because it permits an examination of some of the general issues of community control in a simpler context than is possible with regard to education, for example. Community control in health has fewer of the attributes of selectivity and exclusionism which have been the source of many criticisms of the strategy. Education is a basic socializing medium in society. Law enforcement is a method of social control. Health care is less a means of integrating people with the broader society. Variables of professionalism are especially clear-cut in health because physicians are the epitome of professional exclusiveness and domination of their realm of work.

Advocates of community control of health care make less of an argument in terms of the special needs of low-income, black patients which can only be met if community control is actualized. This argument <u>is</u> used, as we have noted above, but it carries considerably less force and is advanced much more tentatively than in education. Neighborhood health centers in black neighborhoods have stressed blackness as a criterion in hiring of personnel. Eligibility for services is limited by and large to persons living in a defined geographic area and with incomes below the poverty line. However, no one has pursued the argument of the Coleman Report,

which, translated to the concerns of health, would read: Black patients get well faster if treated in the company of whites (except insofar as integrated facilities are better equipped and staffed by virtue of the fact that whites use the facility). Health is a service characterized by rather extreme individuation of consumption. Neighborhood health center doctors and consumers do talk in terms of treating the whole man and ministering to the entire community, but in practice the basics of treatment continue to be directed at individual patients. Preventive medicine, which is a significant part of the program of neighborhood centers, does address whole sectors of the community, but this is just one of the types of care which they provide. Treatment and rehabilitation can by no stretch of the imagination be purveyed to groups in the same sense as education can be rendered through classroom instruction of groups of students. Individual students are taught in the schools, but public discussion of education goes well beyond consideration of average reading levels and standards of academic accomplishment.

Health demands are always expressed with reference to the standards of the dominant society. Health consumers do articulate different objectives and preferred programmatic approaches, but always with at least implicit reference to and acceptance of the health standards of the dominant society. However, the popular concept of medicine as a unitary set of procedures and professional approaches and tools is not accepted in its entirety. The movement

for neighborhood health programs challenges the notion that the present professional procedures are adequate and above reproach. Nonetheless, concepts and standards of health are shared by different socio-economic classes more than they are differentiated. In fact, there is considerable evidence in support of the proposition that poor persons espouse rather traditional measures of the quality of health care.[15]

The case of health has particular relevance in light of the fact that the federal government's enthusiasm for neighborhood health programs was premised at least in part on the belief that they provided a way to attack the causes and conditions of poverty in a politically less volatile manner than through Community Action Programs.[16] The question of why health was conceived of as less politically volatile makes the study of community control of health services and facilities particularly interesting. Why the assumption of political quietude has proved to be partially incorrect is another source of information on the causal dynamics of these issues.

Another difference with health is that the issue of legitimacy of programmatic intervention is less salient. This question is linked to the point that health has a lesser socialization function.

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[15]Eliot Friedson, Patients' Views of Medical Practice (New York: Russell Sage Foundation), 1961.

Samuel W. Bloom, The Doctor and This Patient, A Sociological Interpretation (New York: Russell Sage Foundation), 1963.

[16]Gordon, op. cit., p. 421.

The demand for community control of health programs sees greater accountability as instrumental to better care. But there is less a sense on the part of black communities that the health institutions *per se* are illegitimate in their very presence and relationship to the black communities. They are imperfect in numerous aspects of the quality of care rendered and how it is delivered, but the basic question of institutional legitimacy carries less weight than it does in some other social services.

REQUIREMENTS OF ORGANIZATIONAL MAINTENANCE AND ENHANCEMENT

Just what are the requirements of organizational maintenance and enhancement? They include: (1) maintenance of individual roles and of the relationships among different roles in the organization, (2) sustaining organizational performance in those ways most directly tied to fulfilling its *raison d'etre*, and (3) maintaining relationships as they stand with organizational constituencies. According to Talcott Parsons, the maintenance problems of an organization include being able to adapt to changing situations, accomplishing some level of goals, providing for integration of its members, and dealing with internal tensions and latent pattern maintenance.[17]

The accomplishment of successful organizational maintenance

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[17] Talcott Parsons, *Structure and Process in Modern Societies* (New York: The Free Press, 1960), pp. 16-27 *passim*.

and enhancement requires a strategy of dynamic conservatism, rather than standing pat and sticking rigidly to the established ways of doing things. The component requirements of organizational maintenance sketched above are subject to change. They do in the natural course of events change: other organizations begin to perform some of those functions which define its raison d'etre, the composition of its constituencies shift, and so forth.

In systems of political representation, representatives report to and are maintained by constituencies, who may be the voters or residents of a district or any body of supporters. A major set of constraints on the behavior of consumer representatives and other actors in conflicts about participation and control are the interests of their constituencies. The behavior of program employees is constrained by more institutionalized constituencies or the organizational needs of the organization for which they work. These factors determine the range of attitudes and behaviors possible within different roles. Some observers have noted that CAP representatives of target areas do not have true constituencies and are not subject to continuing pressures from such bodies.[18] The concept of constituencies is, however, a useful tool for looking at the instances of provider-consumer conflict in neighborhood health centers. The case studies which follow will try it on to test the fit.

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[18]Sherry Arnstein, "Citizen Participation - Rhetoric and Reality," draft paper for HUD (March 1967).

The requirements of organizational maintenance and enhancement change over time as an organization grows older and its environment changes. Lipsky and Lounds argue persuasively that there are "contradictions in the organizational requirements inherent in initiating projects with citizen participation components, and ... in consolidating and implementing such projects once they are launched."[19] The organizational requirements of program promotion and image, recruitment of staff and administrative style during program initiation are in some ways opposite to those experienced during program implementation. For instance, during program initiation, administrators tend to oversell the projected benefits of the program, downplay long-run financial uncertainties, advocate a strong dose of consumer control, and point with pride to a host of experimental features planned for the program. As the program is implemented the administrators are forced by client dissatisfactions, the hard criteria of federal evaluations, and the uncertainties of funding to project a greater realism or actual pessimism about program capabilities and prospects for the future. They become much warier of according consumer representatives a measure of control, and experimental features of the programs fade into the woodwork.[20]

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[19] Lipsky and Lounds, op. cit., p. 4.
See also: Louis A. Zurcher, Jr., "Stages of Development in Poverty Program Neighborhood Action Committees," The Journal of Applied Behavioral Science, Vol. 5, No. 2 (April/May/June 1969), pp. 223-258.

[20] Lipsky and Lounds, op. cit., p. 4.

Daniel Smith has outlined the effects of characteristics of the federal program application and funding process on relationships between neighborhood health center administrators and their advisory boards. The pressing deadlines and criteria of federal decision-makers usually mean that few if any consumer representatives are involved in drafting the original program proposal. When consumers learn that the proposal has been submitted, they begin to feel excluded from the process. The announcement of program funding stimulates consumers' expectations and frustrations because the funds do not arrive until some time later, although staff recruitment has necessarily begun, giving consumer representatives the impression that money is being spent on executive salaries. Once the money arrives and begins to be allocated more widely, "community paranoia" dies down somewhat.[21]

PROFESSIONALISM

The medical professions have traditionally been professional in the strictest sense of the term. Therefore, the behavior of physicians and related professionals in the political controversies of neighborhood health centers offers an excellent context for testing the influence of professional orientations on provider-consumer conflict over issues of consumer participation.

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[21]Daniel R. Smith, "Significant Behavioral Characteristics of Consumer-Health-Advisory Bodies that Are Basic to the Educational Training Process," delivered to the Joint OEO-HEW Consumer Training Conference, Silver Springs, Maryland (June 19, 1969), pp. 4-7.

Martin Rein has posited that reform oriented planners can acquire legitimacy for their intervention from one of four mutually exclusive sources: expertise, bureaucratic position, consumer preferences, and professional values.[22] The demand for greater consumer control of neighborhood health facilities is in direct conflict with the professional values of those actors who must respond to the demand. The conflict is sharpened by the fact that the professionals are simultaneously dependent upon their professional values as a source of legitimacy for the experiments and innovations embodied in health center programs. In some cases, professionals have attempted to make professional values and the demand for consumer control complementary by arguing that consumer representatives will support the program innovations which they favor.

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[22]Martin Rein, "Social Planning: The Search for Legitimacy," Social Policy: Issues of Choice and Change (New York: Random House), pp. 193-217.

CHAPTER III - CITIZEN PARTICIPATION - THE HISTORY OF AN IDEOLOGY

In order for an analysis of consumer participation and community control of neighborhood health centers to be instructive, and to build upon studies of citizen participation in other fields, it must be related to the existing literature on citizen participation. This body of thought and experience is by no means a coherent whole from which new work can confidently acquire direction.

> Every effort to reduce its protean-like substance to a definable, systematic, and comprehensible body of thought is resisted by inherent dilemmas -- contradictions between myth and reality and even between different sets of observable social phenomena. Citizen participation virtually defies generalization and delights in reducing abstractions to dust."[1]

The evidence that has been collected on the subject is "contradictory, inconclusive, particularistic, and overly qualified by the dictates of time, place and circumstance."[2]

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[1]Hans B. C. Spiegel and Stephen D. Mittenthal, "The Many Faces of Citizen Participation: A Bibliographic Overview," in Hans B.C. Spiegel (ed.), Citizen Participation in Urban Development, Vol. I - Concepts and Issues (Washington, D.C.: Center for Community Affairs, NTL Institute for Applied Behavioral Science, 1968), pp. 3-4.

[2]Sherry R. Arnstein, "Eight Rungs on the Ladder," in Edgar S. Cahn and Barry A. Passett, Citizen Participation, A Case Book in Democracy (Trenton, N.J.: The New Jersey Community Action Training Institute, 1969), p. 336.

It has been an attractive but idle wish that new programs which call for citizen participation will avoid the mistakes of earlier ones. One veteran of the field has written of "lessons that don't need to be relearned."[3] The tendency has been for each to recapitulate elements of the history of its predecessors, although often in telescoped or capsulized form. This has been the case with consumer participation and community control of neighborhood health programs as well. The very fact of history repeating itself in this regard is proof that the problems and limitations of the concept derive not so much from the particular administrative procedures and mechanisms contrived, but in persistent conflicts among the parties to these programs and the tensions among the divergent values and objectives to which they subscribe. It has been noted that

> Citizen participation is largely a slogan. It has various meanings and forms which co-exist and yet partially succeed each other. Its major forms are still being forged, for no resolution satisfied the diverse interest groups or the expectations invested in it. As the problems of one approach become evident, another model emerges to prominence.[4]

This chapter seeks to translate the issues introduced in Chapter I and clarified by the definitions outlined in Chapter II into the research questions which will follow in Chapter IV. The problem of what specific questions to ask is approached by reviewing

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[3]Sherry R. Arnstein, "Citizen Participation - Rhetoric and Reality," paper prepared for HUD, July 1967.

[4]Martin Rein, "Citizen Participation and Poverty," Social Policy: Issues of Choice and Change (New York: Random House, 1970), p. 354.

the history of the concept of citizen participation, which is the parent of the younger concepts, consumer participation and community control. The geneology is traced by reviewing the experience of citizen participation in successive programs of public intervention and the evolving treatment of this experience by academic and other observors. This review constitutes the history of an ideology. It indicates those areas of the experience most thoroughly studied and those consistently ignored. The latter is one criterion for generating the list of research questions which is presented in the following chapter.

It is a major assumption of this dissertation that local conditions are very important determinants of patterns of consumer participation and community control. However, they have been stressed at the expense of other significant variables, namely the conceptual framework of the actors in these local dramas and aspects of the organizational structures of the groups involved. Both of these sets of variables may be more susceptible to change by new programs such as neighborhood health centers. Therefore they demand special attention at this time.

When people use the term "citizen participation," and argue about how it should be handled in a given context, they do so in a manner which suggests that the arguments are extensions of their world views, rather than merely expressions of a particular role or professional orientation. The global inclusiveness of the subject is not surprising because the concepts involved do

touch on a host of ideas which are integral to basic notions of democracy and which are tied directly to deeply felt beliefs and attitudes about how social life should be ordered and how group decisions should be made. Looking at citizen participation as an ideology is useful because it helps to explain the capacity of the concept to subsume conflicting objectives and notions. It helps to explain the very breadth and range of these functions and objectives.

Ideology is taken to mean here a systematic, interrelated body of ideas or concepts. The separate components are mutually reinforcing and together comprise an encompassing perspective which is applied to all instances of a broad class of situations or events. The term implies a certain intensity of conviction. Ideology does not require much in the way of scientific proof. It survives happily with mutually supporting and interrelated contentions -- any or all of which may be unsupported by scientific evidence. Ideology blithely and summarily dismisses data which contradicts its tenets. It is, however, nourished by real trends which deeply affect people's lives and which they feel profoundly.

Ideology as used here does not carry the perjorative connotations often implied in common usage. It does not mean whatever one is against. Karl Mannheim describes the basis of these negative meanings: "We begin to treat our adversary's views as ideologies only when we no longer consider them as calculated lies and when we sense in his total behavior an

unreliability which we regard as a function of the social situation in which he finds himself."[5] Thus, in interpreting what we have come to regard as ideology-laden statements of another, we look beyond his words to his life situation. The ideology of citizen participation as discussed here is a set of doctrines, not a condemned approach or a set of discredited ideas.

CONTENT OF THE IDEOLOGY

The ideology of citizen participation proclaims a strong conviction in the efficacy of lay involvement in planning as a means of securing a wide variety of benefits to the individual participants and to the programs with which they work. The content of the ideology has shifted recently to include expectations that participation will assist in the development of low-income and racial interest groups, and will facilitate and express the redistribution of political power. In its early days, the ideology emphasized values of social order, consensus and adjustment. More recently, it has accommodated positive values for functions of social conflict. The ideology has a strong bias in favor of service programs and has flourished best in association with these programs. It is a thoroughly middle-class set of ideas with strong roots in the history of participation in voluntary associations, and the literature on general social and political participa-

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[5]Karl Mannheim, Ideology and Utopia (New York: Harcourt, Brace and World, 1962), p.54.

tion. Citizen participation has a mutually supportive relationship with the classical concepts of neighborhood and community in their most classical and romanticized forms.

There is a definite programmatic bias on the part of those professionals who espouse and support some measure of consumer involvement in planning and implementation. Consumer participation and community control require tangible, visible programs. Logically speaking, it is possible for citizens to participate in the formulation of policy which does not manifest itself in programs, but the difficulties confronting the task of organizing citizens to participate in such a venture are immense. They would have little to show for their effort, the product hardly seems worth the trouble, if one can not see and touch it. The dismal experience of master and regional planning efforts which have tried to involve low-income citizens in their deliberations speaks to this point.[6]

There is a strong measure of professional self-interest which supports this bias. Social service professionals owe their jobs to programs. Policies, as contrasted with programs, require less manpower. Programs provide jobs for professionals, and for non-professionals as well. In an unconscious way, consumer participation may be advocated because it sustains this programmatic thrust. For example, recent proposals for reform of the public welfare system seek to reduce the size of the administrative staffs

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[6]See William B. Shore, Public Participation in Regional Planning: A Report of the Second Regional Plan (New York: Regional Plan Association, 1967).

currently required to run welfare offices and who currently depend upon these programs for their livelihood. If service programs acquire greater importance to poor residents as sources of jobs, avenues to greater political power, and so forth, the coalition in support of the maintenance and expansion of these programs will be broadened significantly.

An omnipresent tension accompanying the concept of citizen participation has existed between perceptions of its purpose as integrative and a means of engendering support for a program direction, and its purpose viewed as separatist or adversary, with potential for substantially altering the direction of a program or broader structures of influence. Another way in which this conflict is expressed is in the positions of actors on either side with regard to social conflict. Those who view participation as a means of cooptation or engendering acquiescence tend to view social conflict as undesirable. Participation is viewed as a route to social order. Recently, however, the political range of the ideology has spread to the point where it includes elements of the conflict model. Citizen participation is firmly rooted in the politics of consensus.

Those on the other side reject the use of participation to foster acquiescence, but advocate participation, not always through officially sanctioned channels (because they may be rigged to maneuver acquiescence), to sustain social conflict. Coser's treatise on the social functions of conflict outlines well the

benefits perceived by this group.[7]

The common tendency of discussions of citizen participation to ignore political protest activity is founded in one of the strong rationales for the establishment of channels for citizen involvement and a key element of the ideology: the hope that these instrumentalities of participation will remove the need for overt conflict and protest activities, that they will handle conflicts in a less threatening fashion. Both supporters and critics of citizen participation have viewed it as an instrument of accommodation, a means of reducing pressures for rapid social change.

This tendency has weakened dramatically in later discussions of citizen participation as the concept has taken on functions and objectives which treat conflict differently. The operational interpretation of the maximum feasible participation requirement of the Community Action Program made impossible any continued separation of citizen participation on the one hand and political protests on the other. Political protest activities became, in the eyes of some at least, a legitimate form of citizen participation, one of the recognized modes of expression of that participation.

Several of the benefits which accrue to individual participants and to the broader community and society flow also from

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[7]Lewis Coser, The Functions of Social Conflict (New York: The Free Press, 1957.

activities beyond the official structures for citizen participation and sometimes at direct loggerheads with it. A number of widely heralded instances of citizen participation in urban renewal were stimulated by adverse public reaction to the publicized plans or maneuvers of renewal authorities and other public agencies.[8]

Citizen participation has been primarily a middle class concept in terms of the benefits posited, the mechanisms advanced, and the contexts in which it has been attempted. The key concepts surrounding the idea of citizen participation have their roots in the subjects of participation in voluntary associations, and social and political participation. The most widely heralded instances of "successful" citizen participation have occurred in areas where it was possible for middle-class participants to dominate.[9] The standards which are held for citizen participation in more exclusively lower-income, lower class neighborhoods are middle class in origin and in content. The whole term "citizen participation" strongly implies participation initiated and imposed from above.

By reputation, middle-class Americans are participants. We are stereotyped with some justification as a "nation of joiners." This collective tradition and set of personal experiences has led

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[8]See J. Clarence Davies, Neighborhood Groups and Urban Renewal (New York: Columbia University Press, 1966).

[9]Peter H. Rossi and Robert A. Dentler, The Politics of Urban Renewal: The Chicago Findings (New York: Free Press of Glencoe, 1961).

Langley C. Keyes, The Rehabilitation Planning Game: A Study in the Diversity of Neighborhood (Cambridge: M.I.T. Press, 1969).

to a pervasive middle class bias to the folklore and mythology on the subject. There exists an implicit assumption that middle class styles of participation and objectives for participation are relevant to problems of the lower class.

DEVELOPMENT OF THE IDEOLOGY

The roots of the ideology of citizen participation reach back hundreds of years. In modern usage, or the current reincarnation, citizen participation has been a post-World War II phenomenon. It survived its youthful years in a heretical, outcast status. Later it became a fashionable guest in a wide variety of government programs. The concept experienced an exhilarating adolescence with the maximum feasible participation requirement of the Community Action Program. When it suffered a rapid drop in favor, its kinship with the activities and aspirations of some segments of society kept it alive in less officially sanctioned forms. Its publicly recognized appearances have been limited and constrained by the cyclically oscillating enthusiasm and temerity of the hosts.

Governmental administrative history may be viewed as a succession of shifts among three dominant values: representativeness, politically neutral competence and executive leadership.[10] One of these values tends to dominate at any one time. A period of emphasis on one creates the public discontent which stimulates

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[10]Herbert Kaufman, "Alienation, Decentralization and Participation," in Public Administration Review, Vol. 29, No. 1 (Jan./Feb. 1969), p. 3.

movements toward another.[11] The current era has witnessed a strong shift toward representativeness. Citizen participation has been seen as a corrective, a means of correcting a deficiency in the democratic system. It is a means of giving more equal voice to groups previously without a forceful say.[12]

The public has grown dissatisfied with the current mechanisms of representation which are numerous and widespread; hence the quest for representativeness has rested on administrative agencies. It has found expression through: (1) placement of spokesmen in strategic positions in organizations or the injection of new bodies (such as civilian review boards) in old administrative structures; (2) establishment of centralized government complaint bureaus (ombudsmen); and (3) extreme administrative decentralization.[13] Consumer representation in neighborhood health centers is a facet of the third alternative; however, more centralized health institutions are making increasing use of the first mode -- placing representatives in decision-making positions at that level. The recent push for community control has been expressed as a

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[11] It might be more accurate to view these as crosscurrents, for there exist today strong movements in the direction of neutral competence and executive leadership as well toward representativeness. These movements conflict with the dominant shift towards representativeness. For instance, the systems-oriented approaches to health care reform noted earlier conflict with the impulses toward community control and achievement of a greater pluralism of decision-making in the health field.

[12] Bernard J. Frieden and Robert Morris, Urban Planning and Social Policy (New York: Basic Books, 1968), p. 178.

[13] Kaufman, op. cit., p. 5.

demand for extreme decentralization of administrative authority (in public education, for example) and also has taken form through the creation of locally-controlled institutions.

The evolution of the participation ideology can be traced through the shifts in the emphasis placed on the various functions and objectives for participation and control specified in the first chapter. It is important to review these functions, objectives and benefits -- positively and negatively valued by different observers -- because the same arguments pertain to current issues in the narrower context of consumer participation and community control in health care. In some ways, the health care controversies over consumer participation and control capsulize or compress into a shorter time span the progress of the arguments as they have been taking place in the succession of urban development programs outlined later on. At the same time, the recent very short history of consumer participation politics in the field of health ties in most directly and immediately with the latest experiences of other substantive areas and other kinds of social services.

The development of citizen participation has been jerky. The factors influencing the process of evolution are difficult to pin down because a tangled mixture of causes produced the patterns which emerged.

> ...in the current history of citizen participation accident, discovery, error, and other forces contributed to the various forms of participation which have evolved.
>
> Social policy tends not to develop in a tidy fashion. The forms of citizen participation evolve

> from a whole set of contradictory, conflicting and accidental forces.[14]

The ideology of citizen participation has moved away from its initial emphasis upon the functions and objectives of improving programs, bettering individual participants, fulfilling democratic ideals, reducing alienation and increasing neighborhood integration and stability, toward greater endorsement of the goals of promoting the growth of low-income interest groups and equalizing the distribution of political power. This evolution has stretched the concept to the point that it is no longer a coherent, internally consistent set of ideas, if it ever really had that status. As a result of this strain, the concept has sprouted two somewhat separate notions, consumer participation and community control, with consumer participation expressing greater loyalty to its heritage. The parent concept is still alive. Consumer participation lives at home and takes care of its progenitor, citizen participation, while community control is the prodigal son.

The function of improving program content, delivery and use has been a standard benefit claimed on behalf of participation. We have noted earlier that this function has been stressed for the neighborhood health centers. Socio-therapy is mentioned with reference to participation in planning and running neighborhood health centers, but with not nearly so much emphasis as has been the case earlier in the history of the ideology. The status

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[14]Rein, op. cit., p. 353.

of the health centers as so clearly and undeniably a services delivery operation inevitably makes objectives of program improvements especially important. Likewise, it seems natural that benefits to individual participants would be emphasized where programmatic content and product are not so precisely defined, as for example with the CAPs whose functions were diffuse and unclear.

A great deal of the literature on citizen participation in programs of urban development and community action has been concerned with how different situational constraints influence the prospects or progress of citizen participation efforts. There exists a substantial body of literature about the influence of such factors as the degree of prior organization, the size of the area in question, various demographic characteristics, and variables of the local political structure.[15] Another observer seconds this emphasis on situational determinants, commenting that

> the character of citizen participation is far more likely to be influenced by the functional compromise of divergent community interests in a given locality than by any set of abstract principles espoused by policy-makers.[16]

Another whole body of interest focuses upon how to handle participation -- the methods, techniques and approaches. This area overlaps more substantially with the interests of this

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[15]Davies, op. cit.
Keyes, op. cit.

[16]Robert C. Seaver, "The Dilemma of Citizen Participation," in Spiegel, op. cit., p. 63.

thesis. Questions of "how to do it" have usually been poorly related to issues of objectives and organizational determinants or constraints.[17]

THE EXPERIENCE OF FEDERAL PROGRAMS

The experience of programs has interacted continuously with the ideology of citizen participation. The history of successive programs has defined and expressed the shifting emphasis upon different goals and functions by climbing up (and down) what Sherry Arnstein has labelled the "eight rungs on the ladder of citizen participation": (1) manipulation, (2) therapy (non-participation); (3) informing, (4) consultation, and (5) placation (degrees of tokenism); (6) partnership, (7) delegated power, and (8) citizen control (degrees of citizen power).[18]

The establishment of a citizens advisory committee was one of the seven requirements of the 1954 Workable Program. In practice, this participation was limited to the city-wide level and to a very general consideration of broad goals for renewal programs.

So long as urban renewal was restricted to slum clearance, renewal administrators actively discouraged citizen participation. Harold Kaplan's study of renewal in Newark concluded that "Far

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[17]"Citizen Participation in Urban Renewal," Columbia Law Review, Vol. 66, No. 3 (March 1966), pp. 486-606.passim.

[18]Arnstein, "Eight Rungs on the Ladder," p. 336.

from being indispensable, citizen participation, in many cases, may prove detrimental to the program's progress."[19] "Limited participation and low visibility seem to be necessary to the system's survival."[20] Kaplan noted that clearance generated hostile responses at the grass roots. "Extensive publicity and more widespread involvement could destroy the routine, low-temperature aspects of the renewal process."[21]

Langley Keyes points out that citizen participation became important in the urban renewal program because the emphasis of the program shifted from clearance to rehabilitation and because the size of the project areas increased. The greater citizens' role emerged from the fact that the renewal programs had a greater need for citizen's support in order to succeed, in order to stimulate widespread rehabilitation of an area, and because many residents would be remaining in the project areas, whereas before relocation had been total.[22]

This rationale parallels the case of neighborhood health centers, which have a strong need for residents' support in order to motivate optimal use of the new facility, protection of its physical plant, and recruitment of professional and non-professional employees.

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[19]Harold Kaplan, The Politics of Urban Renewal: Slum Clearance in Newark (New York: Columbia University Press, 1963), p. 164.

[20]Ibid.

[21]Ibid.

[22]Keyes, op. cit., pp. 5-6.

The most important and immediate precursor of consumer participation in health is citizen participation in the Community Action Programs. At the local level, many of the neighborhood health centers were initiated through Community Action Agencies and many have organizational ties with the CAA. The CAA sometimes serves as the grantee agency and selection of health consumer representatives often occurs through the mechanisms of citizen participation of the CAA.

The "maximum feasible participation" requirement of the Community Action Program was "preceded neither by a historical legacy, a searching analysis, nor an active constituency."[23] The draftsmen of the Economic Opportunity Act were primarily concerned with providing a federal incentive for cooperation among local social service agencies.[24] There is no evidence of a thoughtful commitment to participation of the poor by Congress. This goal of cooperation among social service agencies was in direct conflict with objectives of maximal residents' involvement. The legislation was drafted during a period of domestic tranquility..."this false calm occurred during a latency period in the development of independent poor people's organizations which, in maturity, have been more politically assertive than seemed

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[23] S. M. Miller and Martin Rein, "Participation, Poverty, and Administration," Public Administration Review, Vol. 29, No. 1 (Jan./Feb. 1969), p. 15.

[24] "Participation of the Poor: Section 202 (a) (3) Organization under the Economic Opportunity Actiof 1964," Yale Law Journal, Vol. 75, No. 4 (March 1966), p. 602.

possible in the winter of 1964."[25]

A key tension in the programs of community action financed by the Ford Foundation and the President's Committee on Juvenile Delinquency, and one which carried over into the Community Action Programs, was between the professionals' espousal of rationalized scientific planning and the goal of program responsiveness to the poor.[26]

Marris and Rein state that

> As a movement of reform...community action is very different from, say, the campaign for civil rights or medical care. These are concerned with particular improvements in society. But the projects were more concerned with the processes of society at large -- with the way institutions adapted to each other and to changing needs, with the strands of leadership which had to be drawn together and bound to the urgent problems of city life.[27]

The distinction is well taken, but misses the fact so apparent now several years later -- that the movement for reform of medical care has intertwined with its purely health care objectives, an agenda of concerns about the "processes of society at large." This very fact of the objectives of medical care reform including important, relatively salient non-health goals has been a key factor in influencing the conflicts about issues of consumer participation and community control.

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[25] Ibid., p. 605.

[26] Peter Marris and Martin Rein, Dilemmas of Social Reform, Poverty and Community Action in the United States (New York: Atherton Press, 1967).

[27] Ibid., p. 227.

A comprehensive study of community representation in community action programs concluded that "maximum feasible participation" did have a significant impact on the CAAs by providing new opportunities for representation and by encouraging poor persons to organize for changes to attack poverty.[28] The CAPs have developed new leaders.[29] The programs made visible issues which were formerly hidden, and made the public and decision-makers more aware of the problems of poverty.[30]

Alternative modes of resident participation in the CAPs were social action, employment, CAP policy-making, and program development.[31] The level and patterns of participation were affected more by the characteristics of individual cities than by OEO requirements. Important among these characteristics were: city population size (larger cities have higher participation) and the

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[28]Florence Heller School for Advanced Studies in Social Welfare, Brandeis University, "Community Representation in Community Action Programs," Final Report to OEO, March 1969, p. 45.

[29]Extending consumer participation has often meant overextending the already overextended. Since consumer participation is in most instances a classical instance of "creaming" off the most upwardly mobile, able and articulate of the poor, there is some question as to what expanded opportunities for participation and greater authority for participation has meant and will mean. It seems as likely that the cream is being curdled or soured as it is that a larger number of persons are being involved.

[30]Sanford L. Kravitz, "The Community Action Program in Perspective," in Warner Bloomberg, Jr., and Henry J. Schmandt (eds.), Power, Poverty and Urban Policy, Vol. 2 (Beverly Hills, California: Sage Publications, 1968), pp. 259-283.

[31]Ralph M. Kramer, Participation of the Poor, Comparative Community Case Studies in the War on Poverty (Englewood Cliffs, N.J.: Prentice-Hall), 1969.

size of the black population within the city.[32] Factors which limited participation included: restricted ability of the CAA board to make important decisions, restricted definitions by the board of its own responsibilities, and "inherent limitations in the pattern of organizing associations on the basis of residential neighborhoods." Basing organizing efforts on neighborhood units "emphasizes the unique problems and interests of separate geographic areas rather than the interests of low-income persons throughout the city."[33]

Citizen participation in the CAPs occurred mostly in the planning stages. When participation was sustained during implementation, it was frequently associated with disappointing program results.[34] In most CAPs, there was no commitment to giving power to the poor, but instead an emphasis on providing jobs, social services, educational improvements and the like.[35]

In commenting on the origins of community action, Marris and Rein note the conflicts stirred up by the necessity of trying to develop program strategies which were simultaneously politically viable, radically democratic and scientifically rational.[36] The

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[32]Florence Hiller School, op. cit., pp. 46-47.

[33]Ibid., p. 47.

[34]S. M. Miller, quoted in Alan Altshuler, Community Control, The Black Demand for Participation in Large American Cities (New York: Pegasus, 1970),p. 53.

[35]Howard W. Hallman, "The Community Action Program: An Interpretive Analysis, in Bloomberg and Schmandt, op. cit., pp. 285-311.

[36]Marris and Rein, op. cit., p. 9.

same dilemma confronts the neighborhood health centers, but with a different balance. The requirement of scientific rationality is a strong given because the forms of health care treatment are firmly set by tradition and values. Even with the addition of a variety of innovative procedures and supplementary departments, the content and structure of the services are already set or predetermined. The requirements of political viability include needing to secure the acquiescence and support of a range of medical agencies, institutions and groups to whom the neighborhood health center constitutes somewhat of a threat. The centers are expected by some to be radically democratic -- the federal guidelines require a mild level of consumer participation -- but this goal is rejected by others. The expectation of their being a vehicle of radical democracy derives in part from the conceptions of how participation and control fit in with the needs of an effective service program, but they stem also from the demand for participation generated by the anti-poverty program which has had to search for new programmatic contexts as the CAP funds were cut back.

CONCEPTUAL ROOTS

SOCIAL AND POLITICAL PARTICIPATION

Our notions about citizen participation in the planning and running of programs of urban intervention contain a curious mixture of ideas borrowed from, and initially developed with regard to,

social participation and political participation. The literature on both of these subjects is pertinent to issues of citizen participation in program planning or anti-poverty community organization. Tracing the process of carry-over helps to illuminate some of the expectations commonly held for citizen participation and to better define elements of the ideology of participation. There has been a strong tendency for those concerned with citizen participation to lift notions from these bodies of literature without much discretion in their application.[37]

Both literatures suggest that an effective approach to citizen participation in a low-income, lower socio-economic status area is to organize those residents who deviate significantly from the norms of their residential area or class in terms of their degree of alienation, socio-economic status, and so forth. Thus the literature on social and political participation can be used to make a strong case for "creaming," or organizing the most able, articulate and motivated, who may be poor representatives of conditions. The question then becomes: are they good representations of the interests of their neighbors who are less well equipped to participate?

It is significant that the notions we hold for citizen participation borrow from both of these traditions, not just from the political, as might be expected given the ostensibly

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[37]It should be noted, of course, that program planners take their cues less directly from the academic literature than from the professional folk wisdom which is sustained in part by that body of intellectual work.

political nature of the anti-poverty enterprises involved. The objective of socio-therapy for consumer participation fits well with notions of social participation, with handling citizen participation in response to what are identified and seen as obstacles to social participation.

A major means through which conflicts over goals and objectives for participation are masked in program planning is by reference to causal determinants of participation -- both social and political -- and to ways of overcoming these barriers. What is disguised are such things as the basic tension between participation as a means of socialization and adjustment to what exists and as a means of mobilizing political pressures to change the status quo.

The literature on social participation exhibits a primary emphasis on variables of socio-economic status. A host of studies indicate a positive association between socio-economic status and participation in formal organizations.[38] There is less difference in patterns of involvement in informal groups. There has been a strong current of thought in citizen participation discussions which accepts the greater compatibility of

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[38]Morris Axelrod, "Urban Structure and Social Participation," American Sociological Review, Vol. 21, No. 1 (Jan. 1956), pp. 13-18.

Wendell Bell and Maryanne T. Force, "Urban Neighborhood Types of Participation in Formal Association," American Sociological Review, Vol. 21, No. 1 (Jan. 1956), pp. 25-34.

informal types of organization with the associational patterns of lower class areas.

These general conclusions are complemented by studies of the relationship between life style and participation rates and types. Familistic "areas are characterized by more extensive involvement of residents in the network of neighboring relations and local voluntary organizations. The high urban areas are characterized by an absence of neighboring and a lack of involvement in local groups."[39] Lower socio-economic class has been associated with lower participation in organizations and higher participation of a type characterized as "neighboring." This body of literature reinforces the conviction that formal organizations are not congenial to the groups from which, theoretically, consumer representatives in neighborhood health centers will be drawn.

Students of political participation have concentrated on variables of power structure, types of election, length of residence, alienation, socio-economic status, participation in formal organizations, and size of governmental unit.[40] The evidence indicates positive relationships between political participation and socio-economic status and involvement with voluntary organizations.

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[39]Dale Rogers Marshall, "Who Participates in What? A Bibliographical Essay on Individual Participation in Urban Areas," Urban Affairs Quarterly (December 1968), p. 207.

[40]Ibid., pp. 209-10.

Participation in a consumer representative council or committee would seem to be a hybrid of political and social participation. It is often expressed in elective positions, yet it serves important social functions for many of the participants. It is not equivalent to political parties, but in some cases behaves not dissimilarly from the classical ward political machines.

VOLUNTEERING

The current movement toward citizen participation can be seen as an integral extension of the American tradition of extensive participation in voluntary associations. Although the earlier involvement in voluntary associations did not stir up the same kind of political controversy which is alive today, these groups were involved in many reform efforts which stimulated bitter response from the established interests and agencies. If seen as a modern-day form of volunteerism, the movement for consumer participation and community control seem less politically revolutionary, and may be thought of more as a shifting of roles and organizational purposes which maintains social functions which have always, to some extent, been undertaken by lay persons and associations.

The roles expected of yesterday's citizen volunteer coincide with some of those allocated to today's citizen participant. The citizen volunteer identified needs and problems requiring services,

created and directed agencies, contributed knowledge, skill and interest; interpreted and sold programs to potential users and to financial backers.[41]

The transition from citizen participation in voluntary organizations to citizen involvement in quasi-governmental units is an inevitable consequence of the expanded government role in financing and overseeing social service programs. The health and welfare agencies who epitomized volunteerism perceive the issues of transition in terms of a shifting context for involvement, as well as a recognition that some forms of volunteer work are on the decline and that new types of participation are taking over.

> The scope of welfare activities in which volunteers engage has completed a cycle: starting with reform programs embodying relief, housing, sanitation, and employment practices; moving through a period which narrowed welfare activities to those engaged in by the growing social work and health profession and practiced primarily in family and child welfare, recreation and informal education, and health agencies; and now expanded to services which include preventive health services, urban renewal, chronic illness and rehabilitation, international social welfare, and community planning.[42]

The National Commission on Community Health Services in its 1966 report Health is a Community Affair states that "extension of this tradition of voluntary citizen participation will be essential in guiding the development of community health efforts and in pro-

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[41]Violet M. Sider, "The Citizen Volunteer in Historical Perspective," in Nathan E. Cohen (ed.), The Citizen Volunteer (New York: Harper and Bros., 1960), pp. 38-39.

[42]Ibid., pp. 57-58.

viding important elements of service."[43] Participation is seen as a route to enhancing the appropriateness, quality and efficiency of programs and services.[44]

> This is based on no simplistic notion that all wisdom resides in Main Street or arises from sylvan glens. Rather it is simple recognition that action to mitigate today's health problems requires the informed involvement and participation of the individuals and institutions which comprise the problems and finance the solutions.[45]

The report's view of the process is distinctly collaborative and non-adversary. Persons and organizations who subscribe to these objectives for consumer participation are in latent conflict with the proponents of participation as an instrument of institutional change. The conflict is apparent from the roots of the volunteer movement and is sustained by the self-interests of the groups and organizations of that movement.

COMPLEMENTARY, LINKED CONCEPTS

The ideology of participation has vital conceptual links with concepts of neighborhood and community. A focus on neighborhood and community is an inevitable consequence and a companion premise of a services improvement strategy for reducing poverty. The whole

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[43]National Commission on Community Health Services, Health is a Community Affair (Cambridge, Mass.: Harvard University Press, 1966), p. 219.

[44]Ibid., p. 219.

[45]Ibid., p. 160.

approach of strengthening the institutions of low-income areas is bolstered by the assumptions carried along in concepts of neighborhood and community.[46]

The neighborhood concept frequently acquires operational significance in the drawing of boundaries for target areas, some of which accurately reflect communities as they exist and are perceived by the persons who live in them, and some resemble elaborate gerrymanders. In any case, the neighborhood notion coupled with the idea of catchment areas often saddles an area with problems of getting disparate groups within a defined district to work effectively together although their interests may be in real conflict with each other.

One of the most successful neighborhood health center administrators, Dr. Harold Wise, has written

> The neighborhood health center as a new approach to the delivery of medical care services had captured the imagination of many people in the health field as well as of the media. Danger is inherent in accepting the idea of "neighborhood" and "family medical care" as "good things" prior to their careful evaluation.... It may be that the neighborhood ... is something that is dead in the era of jet travel and burgeoning suburbs, and that what should be underway is to organize medical care services on a regional basis and to provide

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[46] It is awkward to try to say "area" or "section of the city" or "district" or "piece of land" whenever that is what is meant. But it would be a good principle to follow. The alternative terms, those which are used consistently by persons connected to these programs, are value-laden to the point of seriously overweighting the conceptual baggage of inquiring social scientists.

> people locked in the ghettos with transportation that would make them as mobile as their affluent counterparts.[47]

Milton Kotler, original theoretician of the community corporation, is an avid proponent of the neighborhood concept. His work "attempts to wipe the dust from the idea of neighborhood."[48] He argues that "To understand this new political movement, we must understand the nature of the neighborhood.... We must accept the neighborhood as the source of revolutionary power and local liberty as its modest cause."[49]

Kotler pushes the colonial metaphor to the limit, arguing that cities are controlled by the "central neighborhoods" which are motivated by imperatives of territorial expansion. His image for health care is distinctly separatist, but fails to define real variations in the standards for health care or the type of care which would be implemented by the ideal neighborhood corporation:

> There will be laws pertaining to the health of the neighborhood citizens. These will differ from present health laws, because their purpose will differ. Instead of making doctors rich, the communities will seek the health of their members and legislate programs that relate to the special health needs of the locality.[50]

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[47]Harold B. Wise, "Montefiore Hospital Neighborhood Medical Care Demonstration: A Case Study," Millbank Memorial Fund Quarterly, Vol. 46, No. 3 (July 1968), Part I, p. 305.

[48]Milton Kotler, Neighborhood Government: The Local Foundations of Political Life (New York: Bobbs-Merrill, 1969), p. xiii.

[49]Ibid., p. xii.

[50]Ibid., p. 60.

Citizen participation is a vehicle through which we pay homage to the tenuous concepts of "community" and "neighborhood." It is a means of reaffirming public support for ideas and styles of life embodied by the concepts, and of seeming to pay attention to the persons who live in these areas, without having to deliver the goods. Citizen participation has been associated with real rewards in terms of the allocation of government resources, but it has some payoff for officials who employ the concept even if they do not supply the rewards which participants anticipate receiving for themselves or the areas and groups whom teey represent. Participatory _____ (you fill in the blank) sometimes indicates meaningful involvement, but just as frequently the term is a tipoff that the engagement is illusory, that it is a mechanism or even a gimmick that assuages feelings without accomplishing substantial improvements or changes.

There is a substantial debate which ebbs and flows in its intensity and in the position favored by the majority over the correctness and usefulness of these terms. Neighborhood connotes a degree of cohesion in an area which may be more imagined than real. Herbert Gans has written of how residents of the fabled West End never referred to the area as a whole, but only to discrete sections of it. Only outsiders, city planners and their colleagues in other fields, conceived of it unitarily.[51]

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[51]Herbert J. Gans, Urban Villagers: Group and Class in the Life of Italian-Americans (New York: Free Press of Glencoe, 1962), p. 11.

This continuing debate has important consequences for issues of consumer participation and community control. The terms "neighborhood health center," and "community control" tend to wish away many of the hard obstacles to successful community organization around health issues. The theory of the neighborhood as a cohesive, interactive community is an important buttress to the ideals of citizen participation. A high level of participation is hard to achieve given the various obstacles which are so apparent. An illusory means of diminishing some of these obstacles is to attempt to recreate something approaching the mythical New England village governed by a town meeting. The label "community" sidesteps some difficult issues of legitimacy. If a low-income area is conceived of as a community, fears and accusations about the representativeness of any one group lose their punch. These terms are useful in selling programs. In addition, the terms are consistent with and complement the ideological doctrines of consumer involvement. Some of the functions envisioned for consumer participation and control assume the existence of community or maintain the creation and enhancement of community as an underlying goal.

Unfortunately, this disparity between ideals of community interaction, cohesion and homogeneity and the actual limits to these qualities provides professional critics of consumer involvement with a wedge which are the broken record accusations, "Who do you represent?" and "You aren't truly representative of the

community!" These points are easily made and there is some question of how important full representation is to the fulfillment of many of the objectives and functions of consumer involvement and control. However, the challenges to representation seem legitimate given the romantic overlayer of the labels neighborhood and community.

CHAPTER IV - RESEARCH QUESTIONS

The research questions which motivate the field work of this dissertation emerge from the history and concepts of citizen participation reviewed in the previous chapter. The list reflects also those concerns which are most important points of contention at this period in the evolution of U.S. health care systems and approaches. Although the questions are directed at the experiences of neighborhood health programs, they touch on salient issues in a variety of related social services as well:

1. Inevitability of politics in neighborhood health programs.
2. Causes of consumer demand for greater participation.
3. Main interests of health consumers and their support of innovations.
4. Provider-consumer conflicts over goals for participation and control.
5. Tasks associated with different goals for and functions of participation.
6. Modes of influence available to consumers.
7. Conflicts of consumer participation vs. those related to community control.
8. Effects of different stages of program development and organizational forms.

9. Formal structure vs. actual functioning of participation.
10. Technical assistance.
11. Impacts of consumer participation and control on prospects for broader social change.
12. Demonstration effects of consumer participation.

These topics are outlined below in specific questions. The questions attempt to define separate issues because there is a general tendency in this field of inquiry to ask vague and unrelated queries.[1] The separate questions are closely connected, however, and constitute an effort to look at clusters of the more important issues surrounding the political conflicts and organizational forms of consumer participation and community control. The causal relationships involved are approached as questions rather than hypotheses because the development of the field to date is so rudimentary. The answers which emerge from the case studies will help to develop a set of questions presented in the concluding chapter and to assign priorities indicating which of them demand further researching most urgently.

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[1] G. M. Hochbaum, "Consumer Participation in Health Planning: Toward Conceptual Clarification," American Journal of Public Health, Vol. 59, No. 9 (Sept. 1969), pp. 1698-1705.

1. Inevitability of politics in neighborhood health programs.

> To what extent is the provision of neighborhood health care through federally-sponsored programs inevitably a highly political undertaking?

To persons with any familiarity with recently developed neighborhood health programs, this question would seem idle, the answer obvious, but Joeffry Gordon argues that members of the medical professions "have tended to deny the political dimensions of health care."[2] A standard posture of health providers and administrators has been that health care is a politically neutral service and ought to be kept that way. Some observers, of course, argue that health care has never been outside the political realm. In any case, the doctrines of consumer participation and community control may inject strong and pervasive elements of political process into social service programs.[3] The issue has become not so much whether or not politics are involved in these programs, but how "politicized" they will become -- to what extent they will involve the definition, mobilization and expression of different interests which compete for public sympathies and for scarce resources. Do the federal requirements for consumer participation necessarily produce this level of political activity in neighborhood health programs?

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[2]Jeoffry B. Gordon, M.D., "The Politics of Community Medicine Projects: A Conflict Analysis," Medical Care, Vol. VII, No. 6 (November-December 1969), p. 420.

[3]Elaine R. Savitsky, "The Politics of Neighborhood Health Centers, An Alternative to Mainstream Medical Care in Low-Income Communities" (unpublished Master of City Planning Thesis, M.I.T., June 1970).

2. Causes of consumer demand for greater participation.

> What causes consumers to demand greater participation in planning and running neighborhood health programs? To what extent is it concern over deficiencies in current health services and institutions? How important a cause is consumers' desire for personal or group power? How important a set of causes are individuals' motivations in comparison with organizational determinants?

Health consumers and providers cite a wide variety of reasons why consumer representatives demand greater participation in the development and operation of neighborhood health programs. It is obviously true that a host of individual reasons are involved and that different mixtures of concerns motivate different persons.

Some researchers have argued that participants decide whether or not to participate according to a rather logical rational calculus.[4] They will participate if the benefits deriving to them personally from participating and the benefits which they see flowing from their efforts are worth the personal costs entailed by the commitment. It is important, however, to try to zero in on the more significant determinants of the demand for participation because this focus can lead to a clearer understanding of the true functions of consumer participation and control and to a firmer grasp of some of the reasons underlying conflicts between consumers and providers in these programs.

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[4]Michael Price, "Who Participates and Why: A Case Study of Model Cities, Cambridge," (unpublished Master of City Planning Thesis, M.I.T., June 1969).

Consumers and providers conflict in the extent to which they emphasize consumers' desire to improve the availability and quality of health care as opposed to their interests in using the program as a source of political and economic benefits. Particular attention will be paid to these two reasons, which are not mutually exclusive, but tend to be expressed as opposing, competitive explanations.

When asked, volunteers to organizations and members of associations mention a variety of reasons for their involvement.[5] Which of these interests are most significant in determining membership in consumer councils of neighborhood health programs and encouraging consumer demands for more substantial participation and influence?

Individuals involved in conflict situations often tend to explain the behavior of their opponents by attributing personal motivations to them and by regarding these motivations as the most important causes of their opposition. The relative significance of personal motivations will be compared with an alternative determinant -- aspects of organizational structure and roles. In addition to comparing attributions of motives and to searching for individual responses to organizational pressures, this question will be approached by examining whether consumers and providers who fill particular offices and assume specific responsibilities behave similarly in the two cases being studied.

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[5]David L. Sills, The Volunteers: Means and Ends in a National Organization (Glencoe, Ill.: Free Press, 1957).

3. Main interests of health consumers and their support of innovations.

> What are the main interests of health consumer groups? What types of decisions and areas of policy concern them most? Does substantial consumer participation move a program towards more or less innovative health care?

A common objection to consumer participation and community control is that they will result in lay persons interfering with the work of professionals in the field and infringing on areas of authority and judgment which are properly the exclusive province of professionals. To what extent is this fear borne out in fact? Are consumer representatives at neighborhood health centers prone to meddling in medical questions: Do they interfere with the functions of supervision and administration which full-time staff normally handle?

Of the many hours spent by consumer representative groups on different subjects, which subjects draw most of their attention? What aspects of planning and implementation of these new institutions interest them the most? Which do they concern themselves with most regularly and intensively? The answers to these questions will be sought by trying to determine what contributions to the program are cited by consumers and providers as being the most important results of consumer involvement.

An issue closely related to that of areas of consumer interests is that of whether consumer participation and control disposes a neighborhood health program towards more or less

innovative medical technologies and forms of practice. Professionals who support community control and participation often expect that consumer representatives will align themselves in favor of a variety of pioneering or experimental concepts in the delivery of medical care.[6] These include such notions as treating patients with teams of professionals and greater emphasis on preventive medicine and relating social services to medicine. (It was noted earlier that people often use terms like participation, control and decentralization to mean various things about the content of the services involved and the form in which they are delivered.) On the other hand, there is some evidence in other fields, particularly in education, that consumers who participate in, or control, these services advocate approaches which are rather more conservative than they are innovative.[7] Existing literature in medicine about the doctor-patient relationship may imply that this conservative frame of mind holds true for the neighborhood health programs as well.[8] Do poor persons yearn for the style of medical care which they believe that middle class persons receive or are they favorably disposed to deviations from traditional forms of practice?

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[6]Count D. Gibson, Jr., M.D., "The Columbia Point Health Center and Health Association," paper presented at the Annual Meeting of the American Public Health Association, November 1, 1966.

[7]Robert A. Dentler, "A Critique of Education Projects in Community Action Programs," in Robert A. Dentler, Bernard Mackler, and Mary Ellen Warshauer (eds.), The Urban R's: Race Relations as the Problem in Urban Education (New York: Frederick A. Praeger, 1967), pp. 158-174.

Mayer N. Zald, "Urban Differentiation, Characteristics of Boards of Directors, and Organizational Effectiveness," American Journal of Sociology, Vol. 73, No. 3 (Nov. 1967), pp. 261-272.

[8]Samuel W. Bloom, The Doctor and His Patient, A Sociological Interpretation (New York: Russell Sage Foundation, 1963).

4. Provider-consumer conflicts over goals for participation and control.

> Do providers and consumers of health care at the neighborhood level hold the same goals for consumer participation? If not, in what ways do they differ?
>
> How do goals held by consumers and providers for consumer participation compare with those which their colleagues maintain for community control?
>
> Do providers and consumers perceive events in the development of a neighborhood health program similarly? Why or why not?

A primary determinant of social conflicts are the divergent and contradictory goals held by those involved. The review of citizen participation efforts to date in other fields (Chapter III) outlined a broad variety of goals for participation and control, expressed in terms of anticipated or advocated functions, benefits and objectives.

Joeffry B. Gordon and Milton Davis and Robert Tranquada in their discussions of consumer participation in health programs find useful March and Simon's typology of three conditions determining interorganizational conflict: (1) existence of a felt need for joint decision-making, (2) differences in goals, and/or (3) differences in perception of reality.[9] In their evaluation of the Watts Neighborhood Health Center, Davis and Tranquada emphasize the degree to which differences in perception of reality have influenced

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[9]Gordon, op. cit., p. 424. Milton Davis and Robert Tranquada, "A Sociological Evaluation of the Watts Neighborhood Health Center," Medical Care, Vol. 7, No. 2 (March-April 1969), p. 109. Both articles refer to J. March and H. Simon, "Conflict in Organizations," Ch. 5 of Organizations, (New York: J. Wiley & Sons, 1958).

intergroup conflict there. In Watts the original objectives for the program, as expressed in initial reports, included effecting changes in community cohesion and autonomy. These goals tended to recede as the program was implemented.[10]

A comparison of consumer participation in 27 OEO neighborhood health centers concludes that

> The widespread advocacy of consumer participation by residents of local communities in service programs by no means reflects general agreement regarding the goals of such participation, the forms it should take, or the means for its implementation.[11]

The case studies will compare the goals held by providers and by consumers for consumer participation and control. In addition, they will provide an excellent setting for asking <u>why</u> goals and perceptions of reality are divergent, if in fact they are.

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[10] Davis and Tranquada, <u>op</u>. <u>cit</u>., p. 109.

[11] Gerald Sparer, George B. Dines and Daniel Smith, "Consumer Participation in OEO-Assisted Neighborhood Health Centers," unpublished paper, November 13, 1969, p.20.

5. Tasks associated with different goals for and functions of participation.

> What tasks, responsibilities and prerogatives for consumer representatives are entailed by different goals for and functions of participation and control?

Objectives held for consumer participation and community control are one thing, what is done and accomplished under the banner of consumer involvement is another. Much of the debate on these issues occurs in an extremely emotion-laden context and on a highly ideological plane. Frequently we lose sight of the fact that what is actually happening -- what specific discussions consumer groups are having, what tasks they are performing, what choices and decisions they are making -- is quite separate and different from the functions and goals attributed to these activities. This distinction is true particularly with reference to goals held prior to, and in anticipation of, the performance of tasks by a consumers' council or controlling board. However, it holds also for interpretations of what is going on at the same time that tasks are performed and prerogatives exercised by consumer representatives.

It is often the case that considerable conflict arises in the planning of a neighborhood health program over the appropriate goals and functions of consumer participants. This tends to be followed by conflicts over the tasks and responsibilities actually undertaken. It is important to look at just what the connection is between the two -- the intended and the actual.

Do different goals for consumer participation actually lead to different tasks as well as different levels of influence? What areas of overlap exist among different goals for participation and control? In what ways do disparate goals entail similar and in what ways do they entail disparate tasks and activities?

Some studies of citizen participation have begun to look closely at what it is that groups of consumer representatives do.[12] This type of analysis is leading to new insights about the problems of which these bodies encounter and to more realistic concepts of what they can and cannot accomplish. The case studies presented in Chapter VI and Chapter VII will look at the association between goals and intended functions of participation and the tasks and activities which actually occur.

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[12] Louis A. Zurcher, Jr., "Stages of Development in Poverty Program Neighborhood Action Committees," The Journal of Applied Behavioral Science, Vol. 5, No. 2 (April/May/June 1969), pp.223 - 258.

Davis and Tranquada, op. cit.

Ralph M. Kramer, Participation of the Poor, Comparative Case Studies in the War on Poverty (Englewood Cliffs, N.J.: Prentice-Hall, 1969).

6. Modes of influence available to consumers.

> What modes of influence are available to consumer groups? Are they necessarily restricted to the use of coercion in making their demands felt because they lack access to other modes of influence? How do consumer participation and community control differ on this point?

Jeoffry Gordon has applied to neighborhood health programs the typology of modes of influence developed by Robert Binstock: inducement, coercion, rational persuasion, selling, friendship and authority. Professionals rely on rational persuasion and authority, community groups on coercion.[13] Gordon argues that consumer groups are limited to coercion as a mode of exercising power because they lack the training, background and basic resources to use other modes which tend to be more readily available to providers of health services such as program administrators, government officials and medical agency personnel.

Through what means are consumer groups actually able to express their demands effectively? How do they manage to affect the development of a neighborhood health program? What routes to power do they have in official forms which constitute authority?

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[13]Gordon, op. cit., p. 425, referring to Robert Binstock, "Effective Planning Through Political Influence," American Journal of Public Health, Vol. 59, No. 5 (May 1969), p. 808. The use of "coercion" in this context refers to activity which is forceful and aggressive. The category includes direct action protests and other forms of confrontation. It is distinct from common use of the term as meaning the forceful exercise of authority.

What other modes do they employ which are beyond the realm of officially or publicly sanctioned power? In what ways do they attempt to influence a program and fail? This latter question will help to illuminate areas of the successful exercise of power and may point out where the obstacles lie to the successful employment by consumer representatives of some types of influence and authority. The case studies will describe the presence or absence in two neighborhood health programs of the classical requirements of a successful interest group as one set of possible obstacles to alternative modes of influence.[14]

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[14]David R. Truman, The Governmental Process - Political Interests and Public Opinion (New York: Knopf, 1951), pp. 265 - 270.

7. Conflicts of consumer participation vs. those related to community control.

> Does the existence of a substantial degree of consumer participation, but not consumer control (in the context of firm local limits on the extent of participation), necessarily cause conflict about the proper methods and limits of participation?
>
> Does community control avoid some of these difficulties? How, or how not?

The two cases which follow will provide contrasting examples -- the Denver neighborhood health program characterized by progressively great consumer participation, but not community control, and the Yeatman Health Center which has been run from the beginning by an elected citizens board with formal and complete authority over the program. Does the absence of community control cause certain conflicts to arise and does it determine the course of these conflicts? Conversely, does the existence of community control avoid some conflicts characteristic of the consumer participation model? What is the source of the difference? Does it lie solely with the different levels of authority accorded the consumer groups involved and the manner in which this authority is structured? What other factors and dynamics are involved, if any?

8. Effects of different stages of program development and organizational forms.

> What effects does the process of moving through successive stages of development of a neighborhood health program have on provider-consumer conflicts over participation?
>
> What variables of organizational and group structure influence the development and maintenance of conflict between health consumers and providers? How do these organizational determinants affect consumer-provider conflict?
>
> What effects does moving through successive stages of development have on organizational variables?

Neighborhood health centers are usually conceived a couple of years before they are funded and opened. How does the development of these programs from the initial stages of planning through later phases of implementation alter what is expected of consumer groups by providers and vice versa? A whole body of political science and sociology has treated the dynamics of organizational growth, the process of groups and organizations maturing.[15] A basic conclusion of these

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[15] David L. Sills, "The Succession of Goals," in Amitai Etzioni (ed.), Complex Organizations (New York: Holt, Rinehart and Winston, 1961), pp. 146-159.

Anthony Downs, Inside Bureaucracy (Boston: Little, Brown and Company, 1967), Chapters II, XIII, XIV, and XVI.

John E. Tsonderous, "Organizational Growth," in William A. Glaser and David L. Sills (eds.), The Government of Associations; Selections from the Behavioral Sciences (Totowa, N.J.: Bedminster Press, 1966), pp. 242-245.

Mancur Olson, Jr., The Logic of Collective Action: Public Goods and the Theory of Groups (Cambridge, Mass.: Harvard University Press, 1965), pp. 148-159.

Mayer N. Zald and Roberta Ash, "Social Movement Organizations, Growth, Decay and Change," Social Forces XLIV (March 1966), pp. 327-341.

works has been that the process of organizational aging entails a series of shifts and transitions in the management of the organization or the life of the group.[16] Relationships within the group change and relationships between the group and outside groups or influences evolve also. What are the various stages in the development of neighborhood health programs? What changes delineate the stages and how do they influence conflicts between providers and consumers over participation and control?

The elements of organizational and group structure which will be closely examined include the requirements and processes of membership, patterns of authority and influence within the organization or group, the division of labor or assignment of responsibilities and tasks, and relationships with other organizations and groups.

If we assume that groups and organizations are preoccupied with organizational maintenance and enhancement,[17] in what ways do the requirements of successful maintenance and enhancement change with the passage of time and the development of the centers?

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[16] Zurcher, op. cit.
Michael Lipsky and Morris Lounds, Jr., "On Some Pathologies in Recent Social Planning Involving Citizen Participation: The Case of Health Services," paper prepared for Symposium on Decision-Making and Control in Health Care, National Center for Health Services Research and Development, Rockville, Md., June 1970.

[17] Edward C. Banfield, Political Influence (New York: The Free Press of Glencoe, 1961), p. 12.

9. Formal Structure vs. actual functioning of participation.

> Does the formal structure of consumer participation or control and the roles they imply coincide with the actual functioning of the participating group? If there is a sizable gap between formal structure and actual functioning, what difference does it make?

The formal structure of consumer participation or control tends to reflect the set of publicly recognized and agreed upon goals for consumer participation or control. The formal structure of consumer involvement defines the limits of consumer authority. It constitutes the rules of the game. Does a gap between formal structure and actual functioning indicate growing strain over the appropriate goals and functions for participation or control? Or are there ways in which a continuing imbalance between the two is functional to the program or to the parties involved? Does it reflect a natural, omnipresent difference between rhetoric and reality? How is the gap bridged -- what informal means are contrived to this end?

10. Technical assistance.

> How important is the provision of technical assistance to consumer boards and committees in their development into effective decision-influencing and -making bodies? What is the operational significance of different approaches to rendering technical assistance to health consumer groups?

The history of citizen participation in planning efforts documents a wide spectrum of approaches to technical assistance. The earlier efforts usually included no effort on the part of the sponsoring agency to help the citizen advisory group to do an effective job. Later approaches involved different ways of giving citizens' committees assistance in learning how to operate effectively as a group, in transmitting to them basic background information about the field in which they are working. Periodic workshops have been sponsored in many places, and in others full-time staff have been assigned to work with the consumer groups on a continuing basis. Just how important is technical assistance to consumer participating or controlling groups in neighborhood health? How such assistance should be given, by whom and what it should consist of are hot topics in this field.[18] How do different approaches to rendering technical assistance compare with each other in form and results?

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[18]Daniel R. Smith, "Significant Behavioral Characteristics of Consumer-Health-Advisory Bodies that are Basic to the Educational Training Process," a paper delivered to the Joint OEO-HEW Consumer Training Conference, Silver Springs, Maryland, June 19, 1969.

Alberta W. Parker, "The Consumer as Policy-Maker -- Issues of Training," American Journal of Public Health, Vol. 60, No. 11 (Nov. 1970), pp. 2139-2153.

11. Implications of consumer participation and control for prospects for broader social change.

> Does the participation of consumers in planning and running a neighborhood health program isolate pressures for change of the broader health system or strengthen and focus them? How do consumer participation and community control differ with respect to this kind of impact? Does the development of consumer participation in these programs make them more universalist or more selectivist in their coverage and impact?

The neighborhood health centers are intended primarily to bring better health care to areas previously without adequate services. Some of the supporters of these centers see them also as levers with which to effect much broader changes in the field of health and in other social services as well.[19] With reference to consumer involvement, the hope is that participation in and control over these institutions will lead eventually to greater influence of the poor and the non-professional over health services and facilities at all levels and to basic changes in these institutions.

Do consumer participation and control direct pressures for change inward upon the community in which a neighborhood health center is located and relieve outside agencies and institutions of pressures for change which would otherwise be directed at them? A major criticism of a variety of programs that create and strengthen institutions within the ghettos of the country maintains that this process of "ghetto-gilding" increases the isolation of those

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[19]Robert C. Buxbaum, personal interview, Boston, Mass., Nov. 3, 1969.

districts and actually furthers movement in the direction of separate and unequal services and facilities. What is the evidence in the case studies which follow? Do consumer participation and community control in neighborhood health programs retard change in the broader health systems or do they accelerate it?

This conflict between universalism and selectivity or exclusionism is a central dilemma of participation and control:[20] Are neighborhood health centers a set of parallel and separate institutions which constitute a modern-day version of segregation and which mire black patients in a separate and unequal system of medical care? Leonard Fein argues persuasively that the ideal of community control violates the traditional liberal belief in universalism, and that this accounts for many intellectuals' skepticism about demands for community control.[21] Or do the neighborhood centers provide an ultimate means of access to the mainstream of medical care and service to exert additional pressures on the major medical institutions of the country? Does consumer involvement in administering and planning these new facilities direct the health demands and grievances of low-income citizens inward and away from the broad-scale reforms necessary in this country? Or

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[20]The terms universalism and selectivism are used according to the meanings outlined by S. M. Miller in "Criteria for Antipoverty Policies: A Paradigm for Choice," Poverty and Human Resources Abstracts, Vol. 3, No. 5 (Sept.-Oct. 1968), pp. 3-11.

[21]Leonard J. Fein, "The Limits of Liberalism," Saturday Review (June 20, 1970), pp. 83-96.

is consumer participation and community control a way of amassing broader public support for changes in the dominant system of medical care and of encouraging confrontations for change in specific local situations?

Related to the question of introversion of pressures for change is that of whether consumer participation or community control influences a program to be more or less restrictive in terms of (1) its requirements for eligibility for services, (2) the coverage of services rendered outside the doors of the facility, and (3) the relationships of the consumer group with other groups of consumer representatives or citizens associations.

The director of the Hunter's Point-Bayview Community Health Service in San Francisco has stated:

> The community felt that a double standard of health care should be eliminated. The clinic approach, regardless of how it may be dressed up in new programs which are being set up throughout the country, has never met the real needs of the poor, especially the black poor.[22]

The argument for a "mainstream" approach to improving health care of the poor demands particular attention in light of the hard problems of survival of selectivist programs. Will the neighborhood health centers wither in an economy of scarcity at some future date? This possibility may be countered with the conjecture that health care improvements achieved through a mainstream approach make services to the poor less visible and identifiable in government budgets, and therefore more vulnerable to cutbacks in funding.

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[22]Dr. Arthur H. Coleman, quoted by Hamilton Bims in "The Neighborhood Center: Newest Public Health Remedy," Ebony (Nov. 1970), p. 126.

12. Demonstration effects of consumer participation

> What is demonstrated by consumer participation efforts in neighborhood health programs which are "demonstration projects?" To whom and how does this process of demonstration occur?

Federal sponsorship of the neighborhood health programs was predicated in part on a desire to foster experimentation with new forms for delivering health care services. The health centers emerged in the midst of the Golden Age of the demonstration project. The federal government underwrote the implementation of experimental approaches to delivering public services with the expectation that the resulting experiences would point the way to improvement of programs, that the successes would serve as models for other parts of the country and for further governmentally-sponsored programs. The demonstration projects provided a means of supplying federal funds to projects which the government and Congress were not yet prepared to underwrite on a broad basis. The concept of consumer participation is an important element in those new program approaches about which the federal government has been fundamentally ambivalent.

Some of what is being learned through different approaches to consumer participation is touched upon in the questions outlined immediately above. The contrasting case studies of consumer participation vs. control match competing demonstration projects. From the vantage point of the federal government, at the guts of these programs is the question of just what has been learned, what is

actually done with that knowledge and how it is actually transmitted. Hence another way of phrasing the question is to ask: What are the consumer participation aspects of the demonstration projects in these instances and what dynamics are involved in the fulfillment or lack of fulfillment of those functions implied by the "demonstration" label?

PART II: COMPARATIVE CASE STUDIES

CHAPTER V - CASE STUDY STRUCTURE AND APPROACH

The pair of comparative case studies which follows in Chapter VI and VII were selected because their differences exemplify important policy alternatives in the field of neighborhood health programs, and in particular in their handling of consumer participation elements of those programs. The "experimental" variables are those described in the set of research questions of the preceding chapter. They cluster into three sets of factors: (1) Provider and consumer goals and functions for consumer participation and control, (2) Organizational structures of the sponsoring agencies, and (3) Patterns of development of the programs.

The basic contrast is between the model of consumer participation pursued in the Denver neighborhood health program and the model of community control implemented by the Yeatman Health Center. A number of the questions outlined in Chapter IV can be approached by looking at what has happened in the history of an individual program. The experience of each program provides in itself a wealth of data relevant to the research questions, which will be useful in drawing conclusions without necessarily referring to the other case. The evolution of the Denver program makes possible a comparison of successive approaches to consumer participation in

addition to the most recent confrontation between consumers and providers over ultimate control of the program. It is particularly interesting because it has existed long enough to have tried different approaches to participation. In addition, a short case history of the health components of the Denver Model Cities programs is presented, which provides an opportunity to compare the role of the Department of Health and Hospitals, sponsor of the neighborhood health program, in a different organizational setting and programmatic context.

SIMILARITIES AND DIFFERENCES IN THE CASE STUDY CONTEXTS

The basis of the comparison between the Denver neighborhood health program and the Yeatman Health Center rests on key variables which are roughly constant between the two. The context of local health care systems in which these two programs were conceived and grew are different in some ways, but share some important similarities. A major medical school or schools are present in each city. A local Medical Society is a strong force, but not an entirely dominant pressure group. In both cities a variety of established medical organizations and agencies were wary of the new programs and voiced opposition to them, but their opposition was not a uniform representation of the interests of local health care accociations, organizations and groups. The general political climate of the medical communities in both cities had important elements of heterogeneity and pluralism.

St. Louis proper had a 1970 population estimated at 700,000, Denver's was about 520,000. The Yeatman District numbered approximately 60,000 residents, the anticipated patient population of the Center is 20,000. The registration list at the Eastside Center totalled just under 35,000 at the end of 1969, including a good number of persons no longer eligible for services. The Yeatman Center employs about 50 persons, the Eastside Center around 200. Both Centers, however, fall in the middle range of populations served of neighborhood health centers across the country.

The general objectives of the programs are basically the same. This is natural given that they emerge from the same movement for improved health care in low-income areas. Both take their impetus from the same trends of thought and the same pressures for change. The services which they offer are similarly comprehensive in scope and parallel in approach. Both have attracted exceptionally able administrators and staffs to man their programs and an impressive collection of consumer representatives to express the patients' interests. The type of facilities and the services rendered are roughly equivalent. The conflicts confronting both programs have been similar in kind, if not in substance and outcome.

Local experiences with the anti-poverty program are similar enough to warrant comparison of the neighborhood health centers which relate to them. The histories of both have been turbulent. Both had trouble producing ongoing programs with tangible results. In both, but especially in Denver, organizational ties with the

neighborhood health program have been a particular source of strength for the community action agency as well as a cause of worry.

The health conditions of the target neighborhoods prior to the establishment of the new centers were similar and the existing health care resources on the same order. Health in both cities was an urgent deficit, but hardly among the top priorities of local residents. Various health indices bear out this status. Neither area was experiencing the abject deprivation of many rural areas for whom the advent of a federal grant provided health care where literally none existed before. But both had serious lacks: hospitals were inaccessible, residents could not afford private care, few private physicians were located in the neighborhood, public programs were oriented to categories of disease and they limited eligibility to certain kinds of patients.

It is a generic malady of the case study approach that complete comparability between cases does not exist. In some important ways, the Denver neighborhood health program and the Yeatman Health Center are dissimilar, and in ways which might be expected to influence issues of consumer participation. In order for there to be any solid basis for comparing the two cases, these differences must be identified and taken into account and necessary adjustments made in determining cause and effect relationships.

The date of initiation of the programs is different. Work began on Denver's application in 1964, the Yeatman planning started only in 1967. The Eastside Health Center opened in 1966, the Yeatman Center in 1969. These dates are only a few years apart, but they

are at opposite ends of a whole era in terms of national ideas, values and experience with concepts of consumer participation and community control. When the Eastside Center opened, the notion of having any consumer involvement was considered extremely progressive and highly experimental. There was no federal requirement that an advisory committee of consumers even exist for each health center. A few years later it was routine and the watchword was community control. Thus the two programs being studied had different starting points in terms of what both providers and consumers knew and expected. Although the content of federal requirements for consumer participation in neighborhood health programs had not changed substantially in the interim, the pendulum describing our collective experience with community organization and citizen participation had reached its widest arc with the "maximum feasible participation" of the Community Action Programs and was swinging back in a jerky motion.

The sources of federal funding were different. Denver monies come primarily from OEO's Healthright program, Yeatman's from HEW's 314(e) allocation. The programs have had to respond to separate guidelines and to function under separate administrative organizations. In practice, however, these requirements have not been very dissimilar. Both OEO and HEW have permitted a wide range of local variation on their handling of consumer participation. OEO has taken the brunt of criticism for community organization and participation activities generally, from Congress and everyone else.

By reputation, HEW would be expected to take a more conservative posture of these issues. In actuality, HEW has been somewhat more adventuresome. They sponsor four community controlled centers, OEO only one. Part of the reason for the surprisingly parallel policies of the two agencies is that the HEW program began two years later and the key staff persons running it moved to HEW from jobs with the OEO health programs, and carried a strong commitment in the desirability and efficacy of substantial consumer involvement.

The patient population in both cases were predominantly black, Yeatman's more exclusively so. Denver's Eastside has a number of militant black activists who enjoy some public support in the community. Yeatman is serene by comparison. On the other hand, black militancy in Denver has been a relatively recent phenomenon.

The scale of the programs is vastly different. Although the consumer groups that are the focus of this study relate to facilities of not so disparate size (10,000 sq. feet versus 20,000), the overall programs of which they are a part are of quite different orders of magnitude. The Denver neighborhood health program had a budget in 1969 of $7.8 million. Yeatman's budget for 1970 is just over $1 million. The Denver program employs just over 1000 persons (full-time or full-time equivalents). As mentioned earlier, the Yeatman Health Center boasts a staff of about 50. The effects of this disparity are minimized somewhat by the study's focus on one part of the Denver system, but the Eastside Center is closely integrated with the entire system and its administrative apparatus.

The organizational dynamics of part of the Denver Department of Health and Hospitals are not separable from the whole. The Eastside Center recorded over 100,000 patient encounters in 1969; the Yeatman Center is seeing patients at the rate of approximately 40,000 encounters per year.

Of these differences, the most troublesome are the different political characteristics of the patient populations and the target neighborhoods, and the different scales at which the programs exist. The source of federal funding has less of an impact and the date of initiation affects the first stage of development more than it does the sequence of stages of program development and the transitions experienced. It will be necessary, therefore, to take into account the influence of differing political bases and scales on programs on the events and policies being studied. In the process of undertaking the case studies, a substantial amount of information was collected on both of these potentially contaminating factors, which permits an estimation of their influence to be made with some degree of confidence. An awareness of these differences will at least permit an informed questioning of the results and will provide a basis upon which to speculate as to their causal impact on the events as they unfolded.

A more comprehensive and fairer (but no necessarily more enlightening) comparison, but one requiring resources beyond my command, would have been between the Denver neighborhood health program on the one hand, and Yeatman Health Center plus other St. Louis neighborhood health efforts on the other. Two other neigh-

borhood health centers were in planning stages at the time the St. Louis study was undertaken. One, the Wells-Goodfellow Center, had received months previously an OEO grant of $1.2 million, but was still a long way from establishing a physical facility and providing services, and there was some speculation as to whether it would ever open. A group in the Yalen area was applying for 314(e) monies, but had not received them at the time of this study. Meetings were being held in Washington, D.C., to try to merge these two incipient efforts. In other words, there was nothing else functioning to study in St. Louis which was of the same program approach and federal sponsorship as the Yeatman Health Center. The shaky and incomplete status of neighborhood health facilities in St. Louis does not distinguish it from most other U.S. cities. It does, however, illustrate the extremely impressive nature of the Denver accomplishment to date. The unique spread and coordination of the Denver neighborhood health program is a masterful achievement. Other studies should document the dynamics of their coordinated system and the history of its expansion. This piece of research focuses on parts of that history most relevant to issues of consumer participation. The picture which emerges is not entirely rosy because this is almost never the case in the political controversies surrounding these issues.

The cases are presented in a modified chronological framework. Each begins with a description of the program as it existed at the time of the study.[1] This section is followed by a historical

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[1]Both programs, of course, have continued to evolve since the time of study - April 1970 in the case of Denver, May 1970 for St. Louis.

summary of the process of its development. A background section provides parallel information on the local settings, health conditions, programs and facilities before the neighborhood health program began, and local experiences with other anti-poverty programs. Then the development of the respective programs is traced through their origins, planning periods and the various stages of implementation and organizational maturation.

CHOICE OF RESEARCH METHODS - WHY CASE STUDIES?

The research of this dissertation is analytical rather than holistic because it looks at a particular set of processes within the situations under study rather than focussing upon total systems.[2] The dissertation examines a set of research questions but has as a primary objective in addition to the answering of these questions the generation of others. Thus it is empirical while at the same time exploratory. The research must be deemed analytical because it proceeds by isolating elements from one another, attempting to identify a number of linked relationships and to measure the strength of these linkages.[3] On the other hand, I have denied the possibility or usefulness of measuring the linkages quantitatively and have opted for case studies rather than survey techniques as the most appropriate method of study. It has

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[2]Weiss, "Alternative Methods for Studying Complex Situations," Human Organization, Vol. 25, No. 3 (Fall 1966), p. 199-201.

[3]Ibid.

been argued that

> It is only from a holistic point of view that a case study has merit. The analytic aim of working out interrelations among elements can hardly be advanced by the study of a single case.[4]

Although I have two primary cases, the point remains the same.

Given the theoretical questions and issues that guide this dissertation, the most appropriate research approach was to undertake comparative case studies. The key questions of the thesis focus on elements of process in the development of neighborhood health programs and the relation of consumer participation to this process. Variables of process are particularly difficult to identify and measure. They resist classification. Attempts to classify process variables are enormously expensive and are susceptible to such important sources of error that they frequently produce meaningless categories and enumerations.

The stage of theoretical development of the subject was an added inducement to opt for the case study approach. There are only rudimentary theories and hypotheses enunciated in the skimpy academic literature on citizen participation, and the situation with regard to participation in health programs is even bleaker. The notions guiding federal programs remain at a relatively high level of generality. Discussion among public officials focuses on questions such as whether substantial consumer involvement is

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[4] Ibid., p. 202.

desirable or undesirable and how to handle specific administrative problems in connection with it. Academic treatment of the subject tends to emphasize the testing of notions that relate directly to government policy alternatives because primary support for research in the area comes from federal agencies involved in sponsoring the programs.

The density of the data which I ploughed through was a key ingredient in enabling me to answer the questions underlying the dissertation. A whole wealth of material would have remained unused had I chosen a research method other than that of case studies - survey research, for example.

I gathered a large amount of information about the general attributes and history of the programs. Often this information was only tangentially related to issues of consumer participation. However, I found this kind of material essential to understanding the development of the form and level of consumer involvement. Approaching consumer participation too narrowly pulls it out of the real context which gives it meaning in the first place. There is a general tendency for the federal guidelines, current academic treatment and, to a lesser extent, local administrative practice, to embrace a rather isolated conceptualization of consumer participation. Consumer involvement is treated as an item separate from the substance of the program itself and from the overall politics of the program. This is especially true because of the widespread tendency to deny the existence of a strong political component to the concept. If consumer participation is inevitably

a highly political undertaking, one cannot study it usefully without inquiring into the political conflicts surrounding the program in general, and tracing its expression in ways which are separate from or go beyond the mechanics of formally constituted consumer involvement. Consumer involvement is a shifting segment of the whole political realm of a neighborhood health program. It is inexorably influenced by political conflicts which never find their way onto the agenda of the consumer committee or board. Therefore it is wise to cast one's net widely.

The dissertation is intended to be non-evaluative. Its objectives are to increase understanding rather than utility. The dissertation is at once diagnostic or descriptive, and theoretical. It mixes description geared to generating and elaborating hypotheses and the testing of analytical models with the answering of specific questions and the integration of these findings with relevant theory.

The strongly non-evaluative position and interest had little impact on the perceptions of many of those interviewed, who regard all outside research as evaluative or judgmental. In a sense, from their work orientation and problems, this perspective is an accurate one. In their eyes research either helps or hurts their interests, and other aspects of it are irrelevant. Regardless of its stated purposes, non-evaluative research inevitably maintains a potential for consumption by persons and agencies relevant to the program who may feed its findings into their own, continuing evaluative calculus.

A strict social science protocol would hold that it is highly improper to undertake case studies with a set of questions with implicit hypotheses in mind. The traditional objection is that these hypotheses influence the researcher to prejudge the cases. No matter how carefully he guards against this danger, he will tend to perceive events in ways which conform to the framework of his prior notions and which tend to substantiate at least some of them. My rejection of this position is grounded in two observations: (1) Lack of prior hypotheses can be just as potent a prejudicial force. It can cause the researcher to overlook relationships or to misconstrue items which he records. We inevitably carry with us our own theoretical orientations. (2) One can attempt to guard against this form of bias by being clear about the content of one's preconceptions, but it is absurd to argue that the case student enters the case as a blank slate.

CHOICE OF CASES

Limited resources dictated that I concentrate my efforts on completing a pair of case studies. Therefore I had to choose cases which demonstrated relatively high values of the variables in which I was most interested. The content of my focal questions and my interest in how the stages of development of a program influence the form and extent of consumer participation dictated that I look at programs which had been in operation for some time. I needed to study programs which were similar or at least not too

different in some respects -- political climate and structure of the city, characteristics of the client population of the health program, complexion of the local medical establishment, and other situational constraints -- but which differed sharply on variables of the extent of consumer participation and the structures which guided consumer involvement. A review of those programs in existence led me to believe that Denver's neighborhood health program and the Yeatman Health Center met these criteria admirably. They approach, but do not reach the desired goal of being contrasting ideal types.

Another factor in the choice of cases was ease of entry. It is no longer true that a social scientist can study wherever and however he desires, especially with regard to domestic social welfare programs. This criterion was particularly important with regard to the choice of St. Louis. The few neighborhood health centers characterized by a strong form of consumer participation or local control are staunchly resistant to research overtures by outsiders. I rejected the single OEO-assisted center which operates under community control because it is small and rural. The 314(e) neighborhood health center in Watts has been the subject of continuing research on issues of consumer involvement. I tried to study the Lower Eastside Neighborhood Action center in New York, but was refused permission to work there. The other 314(e) center in the Hunt's Point section of the Bronx I judged to be too heavily conflicted and hostile to outsiders to even approach.

I was anxious to not limit myself to programs which were geographically most accessible to Boston. The larger cities of the Northeast share some characteristics of local government and medical institutional environment which differentiate them from urban areas in other parts of the country. These facts would limit the amount of generalization possible from my results. I went West in search of credibility as well as applicability for my work. I had some acquaintance with consumer participation in health programs in Boston. In fact, the vitality and variety of consumer participation efforts in the Boston area is probably unparalleled except in New York City. However, the many unique characteristics of Boston and its very complicated network of medical institutions and programs argued forcefully against basing the case studies close to home.

Appendix A details the interviewing procedures and other techniques of data-gathering used in researching the case studies.

CHAPTER VI - THE DENVER NEIGHBORHOOD HEALTH PROGRAM

Denver's neighborhood health program, one of the first funded by OEO's Healthright Program, is an example of many of the substantial successes of the neighborhood health center approach to providing medical care to poor areas. It is a technically superb model. However, its development illustrates dramatically the difficult political problems likely to be encountered by neighborhood health programs at the local level.

Denver is by no means a typical neighborhood health center city. In many ways its program remains unique although aspects of its approach have greatly influenced the shape of rewer centers in other parts of the country. The length of time the program has been in operation and the particular set of local conditions make it an especially revealing case study. The universal conflicts between providers and consumers are projected with special clarity and definition in Denver. The structure of its government and anti-poverty program are simpler than in many larger cities. The neighborhood health program there has been extended vigorously, to the point where it constitutes a much more important source of health services to a larger portion of the local population than is usually the case.

Although the Denver neighborhood health program has been lauded nationally and represents an enormous improvement in the health services available to poor areas of the city, it has stimulated a series of conflicts, each with a different set of combatants. At first, part of the Denver medical community and established public and private health and welfare organizations opposed the program. After this challenge was successfully met, the program was shaken by a bitter internal struggle which resulted in the departure of several persons instrumental in the program's early development. In recent months the Department of Health and Hospitals has been locked in a harsh dispute with health consumer representatives over the powers of the Health Boards which advise each center. The local Model Cities mental health program demonstrates a different approach to consumer participation which includes some of the same actors who have had key roles in the growth of the neighborhood health program.

INTRODUCTION

THE NEIGHBORHOOD HEALTH PROGRAM

Denver's neighborhood health program[1] provides family-centered medical care to over 80,000 poor residents through a city-administered

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[1] "Neighborhood health program" refers to the network of health services and facilities operated by the Denver Department of Health andHospitals and funded primarily by OEO. The Model Cities mental health program referred to later is a separate program, with a different set of consumer representatives, but involving the Department of Health and Hospitals as the major provider institution.

network of two neighborhood health centers and eight smaller stations which feed into the larger units. The neighborhood health program is a three-tiered hierarchy of health services and facilities. The program fully merits the label "system," since the coverage and integration of the approach are unparalleled. The system is operated by the Department of Health and Hospitals (DHH) which is a city agency directly responsible to the Mayor and the seven-member Board of Health and Hospitals which he appoints.

Dr. Samuel Johnson, a professor of preventive medicine at the University of Colorado Medical School, joined DHH in 1965 to develop ways of improving health care in low-income areas of the city. As head of the DHH Dept. of Public Health and Preventive Medicine, he and his staff wrote an application to the Office of Economic Opportunity for the creation of a neighborhood health center to give comprehsnive, family-centered care to 20,000 residents of the city's Eastside, an area populated by poor blacks and Mexican-Americans. The local community action agency, Denver War on Poverty (now Denver Opportunity, Inc.--DO) approved the proposal in December 1964. OEO funded the project in August 1965 and the Eastside Neighborhood Health Center opened its doors in March 1966.

In late 1968, DHH was reorganized so that control over the neighborhood health program was taken away from Johnson's department and shifted to the current Manager of DHH, Dr. David Cowen. Dr. Cowen exemplifies the new breed of public hospital administrator nationally who are guiding innovations in the delivery of health care.

He is young, sharp and energetic--qualities shared by his administrative staff. He describes the modern hosptial administrator as "something of a mix of lay physician, health educator, grantsman, accountant, program analyst, research specialist, and, especially, doer."[2] The list is an apt self-description.

According to Cowen, the Denver neighborhood health program is

> designed to use efficiently funds available from all sources, to provide quality care that is available and acceptable to the community, to make maximum use of existing institutions and staff personnel, to acquire and encourage participation of residents, to develop and train new health professionals, and to demonstrate the reality and value of comprehensive health care.[3]

DHH has done a highly imaginative job of piecing together funds from a variety of federal sources--OEO, Children's Bureau, Public Health Service and several other agencies--to support the program. HEW Secretary Elliott L. Richardson has used Denver's experience in speeches decrying the federal red tape which hampers local programs. Richardson notes that DHH's use of twelve different funding sources meant that grants ran for varying periods of time; cash flow was uncertain; and the reporting requirements of separate federal agencies were different. At one point, all twelve agencies audited the program within a forty-five day period.

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[2]David L. Cowen, "Health Administration: A National Frontier," Paper presented at the Association of University Programs in Hospital Administration, Chiago, Ill., April 20, 1969, pp.1-2.

[3]David L. Cowen, "Denver's Neighborhood Health Program," Public Health Reports, Vol. 84, No. 12 (December 1969), p. 1027.

The operation has grown to the point where the neighborhood health program portion of the 1969 DHH budget was over $7.5 million. The figures below detail the sources of the funds which support the program and how they fit into the overall budget of the Department.

TABLE VI-A: 1969 NEIGHBORHOOD HEALTH PROGRAM GRANT EXPENDITURES, BY SOURCE OF FUNDS[a]

	OEO	PROJECT CHILD	MATERNITY & INFANT CARE	USPHS	MODEL CITY: NIMH-HUD	OTHER	TOTAL
Personnel:	$3,327,016	$762,829	$634,705	$378,486	$24,834*	$569,801	$6,199,682
Recurring supplies:	607,533	27,741	21,728	46,202	DNA	12,167	715,371
Other:	453,627	102,109	78,858	255,063	DNA	60,484	950,141
TOTAL	$4,888,176	$892,679	$735,291	$679,751	$24,834	$642,452	$7,865,194

* Commenced operation in November, 1969

DNA - Does Not Apply

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FUNDING SOURCES

Local: City and County of Denver

Federal: Office of Economic Opportunity
Children's Bureau, Dept. of HEW
U.S. Public Health Service, Dept. of HEW
National Institutes of Health, USPHS, Dept. of HEW
National Institute of Mental Health, USPHS, Dept. of HEW
Social and Rehabilitation Service, Dept. of HEW
Dept. of Housing and Urban Development

State: Colorado Dept. of Institutions
Colorado Dept. of Public Health
Colorado Dept. of Rehabilitation

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[a]Denver Dept. of Health and Hospitals, Denver's Neighborhood Health Program: The Quarterly Report (October, November, December 1969), p.44.

TABLE VI-B: DENVER DEPT. OF HEALTH AND HOSPITALS TOTAL EXPENDITURES FOR 1969 AND BUDGETED FOR 1970[b]

	1969 Total Expenditures	1970 Budget (or Anticipated Funding)
Dept. of Health & Hospitals, City and County of Denver:		
Denver General Hospital	$8,826,798	$10,627,136
Public Health Division	1,042,530	1,227,824
Public Health Nursing (VNS)	1,044,811	1,241,558
Coroner's Office and Forensic Laboratory	122,642	264,636
Medical Practice Fund	376,411	675,000
Total	11,413,192	14,036,154
Federal:		
Neighborhood Health Centers (OEO)	4,888,176	5,202,000
Maternity & Infant Care Project (HEW-Children's Bureau)	735,940	663,000
Project CHILD (HEW-Children's Bureau)	892,679	950,000
Family Planning Services (HEW-Children's Bureau)	65,888	260,000
Denver Neighborhood Health Program (HEW-USPHS)	679,751	1,167,497
Psychiatric Staffing Grants (HEW-NIMH)	207,397	128,812
Model City Mental Health Program (HEW-NIMH; HUD)	24,834	2,700,000
Other Federal Grants (12 programs)	319,027	252,267
Total	7,813,692	11,323,576
State of Colorado:		
Mental Health Clinics (Dept. of Institutions)	158,202	207,511
Public Health Services (Dept. of Health)	61,723	109,000
Metro Denver TB Control (Dept. of Health)	2,579	76,369
Rehabilitation Services (Dept. of Rehabilitation)	49,630	55,112
Meat Inspection Program (Dept. of Agriculture)	8,585	18,000
Other State Grants (3 programs)	4,415	--
Total	285,134	465,992
Total: City, Federal and State	$19,512,018	$25,825,722

[b]Denver Dept. of Health and Hospitals, op. cit., p. 45.

Patients made 318,000 visits to facilities of the neighborhood health program in 1969. This represents 44% of the total numbers of patient encounters (including inpatient days at Denver General Hospital) recorded by the entire Department during the same year.

TABLE VI-C: PERCENTAGE DISTRIBUTION OF PATIENTS BY RACIAL AND ETHNIC GROUPS[c]

	Anglo	Black	Spanish surname	Other
City and County of Denver, total population	78%	9	11	2
Denver General Hospital inpatients	43	18	37	2
Neighborhood Health Program patients	19	24	55	2
Eastside Neighborhood Health Center patients	7	52	39	2

The Eastside Health Center, focus of this case study, supplies a full range of ambulatory care services to area residents. In addition to medical treatment, the Center's comprehensive care includes dental, social services, visiting nurses, mental health, environmental health, x-ray and laboratory, pharmacy, nutrition, maternity and health education.

The center has approximately 20,000 sq. ft. of space on two floors. The third floor is still used for apartments. The exterior appearance is plain and unassuming, in striking contrast to the

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[c]Denver Dept. of Health and Hospitals, op. cit., p. 1 (opposite).

shiny architecture one associates with new public buildings. Inside, the facility has a warm informal atmosphere. The waiting room and halls are crowded, but the staff are friendly and the building is comfortably small. The first floor contains examining rooms, an eight-chair dental units, and a pharmacy. Social services, a mental health program and administrative offices are upstairs. The program anticipated a volume of 450 patient visits a week at the Eastside Center, but this level was exceeded immediately after the Center opened. The current load exceeds 2,000 visits each week. A family of four with an annual income of up to $3,000 receives free care. Families with higher incomes, graduated by family size, are charged for services according to an ability-to-pay fee scale.

Since the establishment of the first center, eight small health stations have been set up to make services available to residents within walking distance of their homes. The stations handle normal health problems and refer patients to the Centers for specialized treatment. The first station opened in July, 1966. Three new ones were added in 1967 and three in 1968. In April, a second neighborhood health center, the Westside Center, was opened in a predominantly Mexican-American section of the city.

The stations are approximately 3-5,000 sq. ft. in size, with staffs of 15 to 20.[4] They provide services to 3-5,000 residents. Residents living close to a Center use it rather than a station as their primary source of care. A fleet of radio-equipped and

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[4]The first seven stations established by the program fit this model. The most recent, located in a shopping center in the Park Hill district, has a staff almost twice the size of the others and a floor area of 7,000 sq. ft.

dispatched station wagons provides transportation for patients who need it. The University of Colorado Medical Center and Children's Hospital, in addition to Denver General, serve as backup facilities.

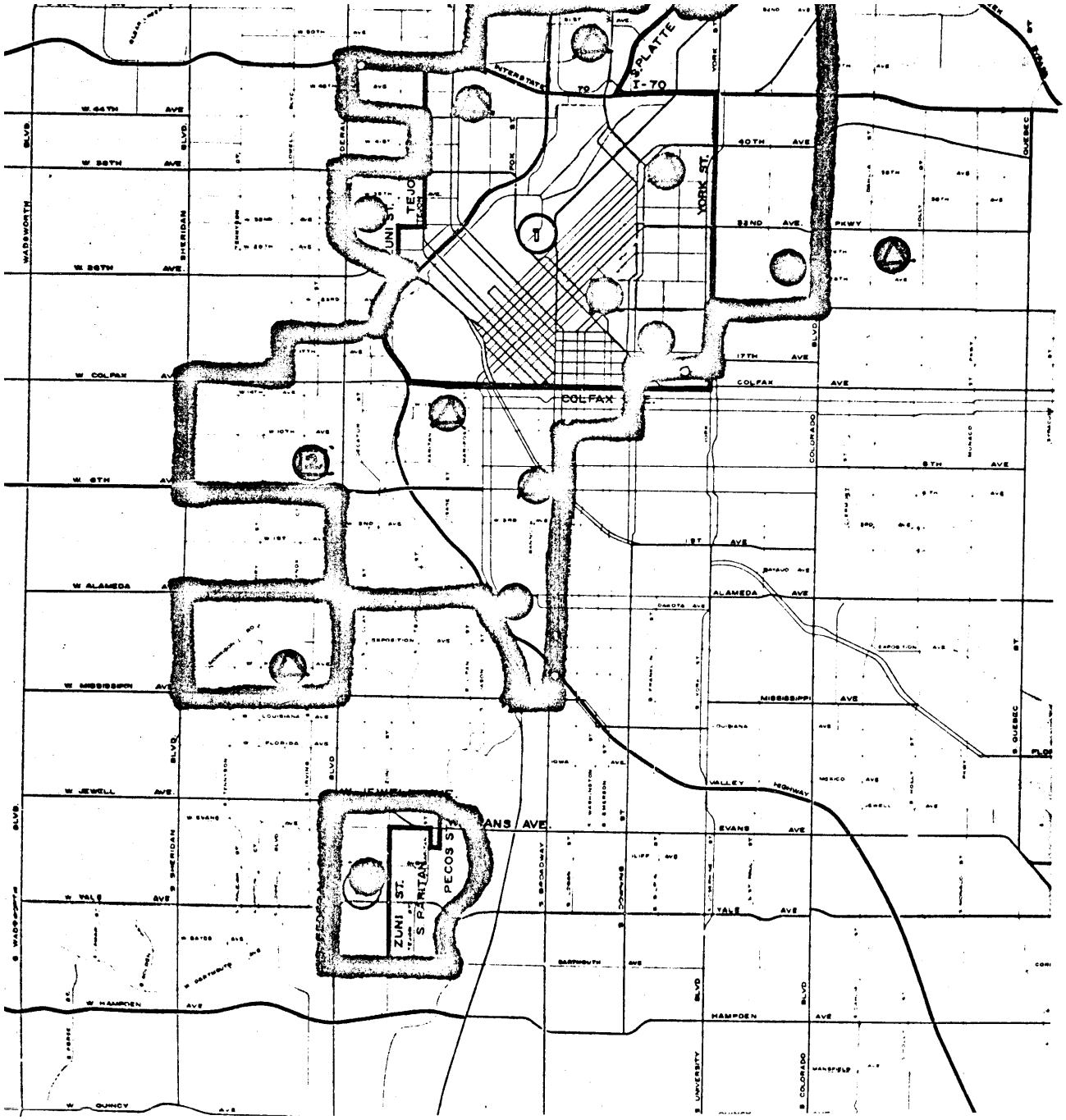

FIG. VI-A: LOCATION OF FACILITIES, NEIGHBORHOOD HEALTH PROGRAM

LEGEND:

- NEIGHBORHOOD HEALTH CENTERS
  1. EASTSIDE
  2. WESTSIDE
- HEALTH STATIONS
- PROJECTED NEW HEALTH STATIONS
- POVERTY AREAS SERVED BY NEIGHBORHOOD HEALTH PROGRAM

SHADED AREAS ARE MODEL CITIES TARGET AREAS

Neighborhood residents employed by the program in subprofessional roles were given the new job status of Neighborhood Aide Trainee by the city's Career Service Authority. Approximately one-sixth of the employees of the neighborhood health program fall into this category. The table below outlines the staff positions which it takes to run the neighborhood health program. The Eastside Neighborhood Health Center employs approximately 200 of this total.

TABLE VI-D: NEIGHBORHOOD HEALTH PROGRAM PERSONNEL BY JOB CATEGORY[d]

Career Service and Contract (fulltime or fulltime equivalents employed during quarter):

Physicians	65	Pharmacists & helpers	17 1/2
Dentists	18.1	Health Educators	2
Dental Interns	3	Training professionals	1
Hygienists	5	Research professionals	3
Dental Assistants	13	Clerical support	147 2/3
Psychiatrists	7 1/3	Keypunch, data processes	22
Psychologists	17	Accountants	1
Clinical RNs	54	Environmental Health	1*
Public health nurses	57	Administrators	9
VNS field teams	77*	Maintenance, transportation	35
LPNs	26	Hospital attendants	13
Social workers, Caseworkers	50	Switchboard operators	3 1/3
Nutritionists, Dietitians	19	Program aides	45
Lab and Medical technicians	14.5	Others	29 1/3
X-ray and darkroom techs	13		
		TOTAL	768 4/5

Neighborhood Aide Trainees:

Positions filled during quarter			
Family health counselors	28		
Subprofessional aides	70		
Clerical aides	62		
		TOTAL	160
Number of NAT's employed at beginning of quarter	145		
Number entering during quarter	16		
Number certified as eligible for Career Service during quarter	23		
Number terminated during quarter	11		
		TOTAL EMPLOYEES	928 4/5**

* funded by Department of Health and Hospitals and Visiting Nurse Service

** Approximately 100 Dept. of Health and Hospitals employees funded by the city and not listed above spend from 5% to 100% of their time on health program activities.

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[d]Denver Dept. of Health and Hospitals, op. cit., p.31

THE COMMUNITY SETTING

Denver's Eastside presents striking contrasts to most other sections of the city. Denver as a whole is a young, vibrant western city, a regional center for government, agriculture, transportation, and real estate development. It is the chief port of entry and the economic hub of the Rocky Mountain region. It presents a physical image of cleanliness and spaciousness. Wide streets offer vistas of neighboring mountains. Average levels of education and family income are considerably above the national norm. The population of the metropolitan area is 1 million , that of Denver proper 520,000. The largest minority group are the Spanish-surnamed, with blacks comprising a slightly smaller portion of the population. Blacks, Chicanos, Japanese-Americans and Indians are approximately 20% of the city's residents. The federal government is the largest local employer, supporting 20,000 civilian positions in the metropolitan area.

The Eastside, on the other hand, evidences the social and physical ailments common to central city ghettoes. Figures on unemployment, income, housing conditions, and so forth, describe the all too familiar picture. 28% of all persons over 24 years of age have less than eight years of education. The unemployment rate is more than double the city-wide rate and residents are concentrated in low-skill jobs. 57% of the families have incomes below $5,000 a year.

The Eastside is bounded by the downtown business district to the South and West. It abuts the stock yards and an industrial belt

running along the Platte River. There has been wholesale conversion of single family dwellings in this oldest part of the city into multiple family and non-residential uses. Small commerical zones are scattered throughout the district.

HEALTH CONDITIONS

Before the program came into being, health statistics for the low-income districts of Denver now served by the centers and stations revealed severe health problems. A 1965 Head Start survey found that only 17% of the five-year olds examined had polio and diptheria-tetanus immunizations. The infant mortality rate was 70% higher than that of the rest of the city.[5]

HEALTH SERVICES AND FACILITIES

Denver's dry climate has encouraged the development of a number of renowned chest disease hospitals--National Jewish Hospital, Fitzsimmons General Hospital and Children's Asthma Research Institute. The University of Colorado Medical Center maintains sparkling new facilities in the city. Services and facilities in low-income areas, and on the Eastside in particular, were terribly inadequate. The fragmentary services available were poorly coordinated and offered only episodic care. There were long waiting periods at

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[5]Beverly Collins, "Denver Builds Citywide Health Network," Modern Hospital, Vol.110, No. 5 (May 1968), p.103.

the few existing charity clinics. Of the 1,370 doctors in the metropolitan area, only 10 practiced in the poverty areas.[6] Denver General's outpatient department was recording over 200,000 patients visits per year, more than twice what the facility was designed to handle.

ORGANIZATIONAL FRAMEWORK

Denver Opportunity, Inc. (DO), the local community action agency, is the grantee agency for the neighborhood health program. The Office of Economic Opportunity funds, which comprise a majority share of the program's budget, are passed from DO to the Dept. of Health and Hospitals, the delegate agency. Because DO is the grantee, consumer participation in the neighborhood health program is built around DO's citizen participation mechanisms and structures.

The Mayor appoints the Manager of the Dept. of Health and Hospitals and each years appoints (or reappoints) a member to the seven-member Board which oversees the operation of the Department. Professional and many paraprofessional positions in DHH are covered by civil service. The Mayor appoints members to staggered terms on the Career Service Agency.

Consumer participation in governing the neighborhood health program is regulated by a document titled the Health Board Structure. The Structure is a charter and set of by-laws for the

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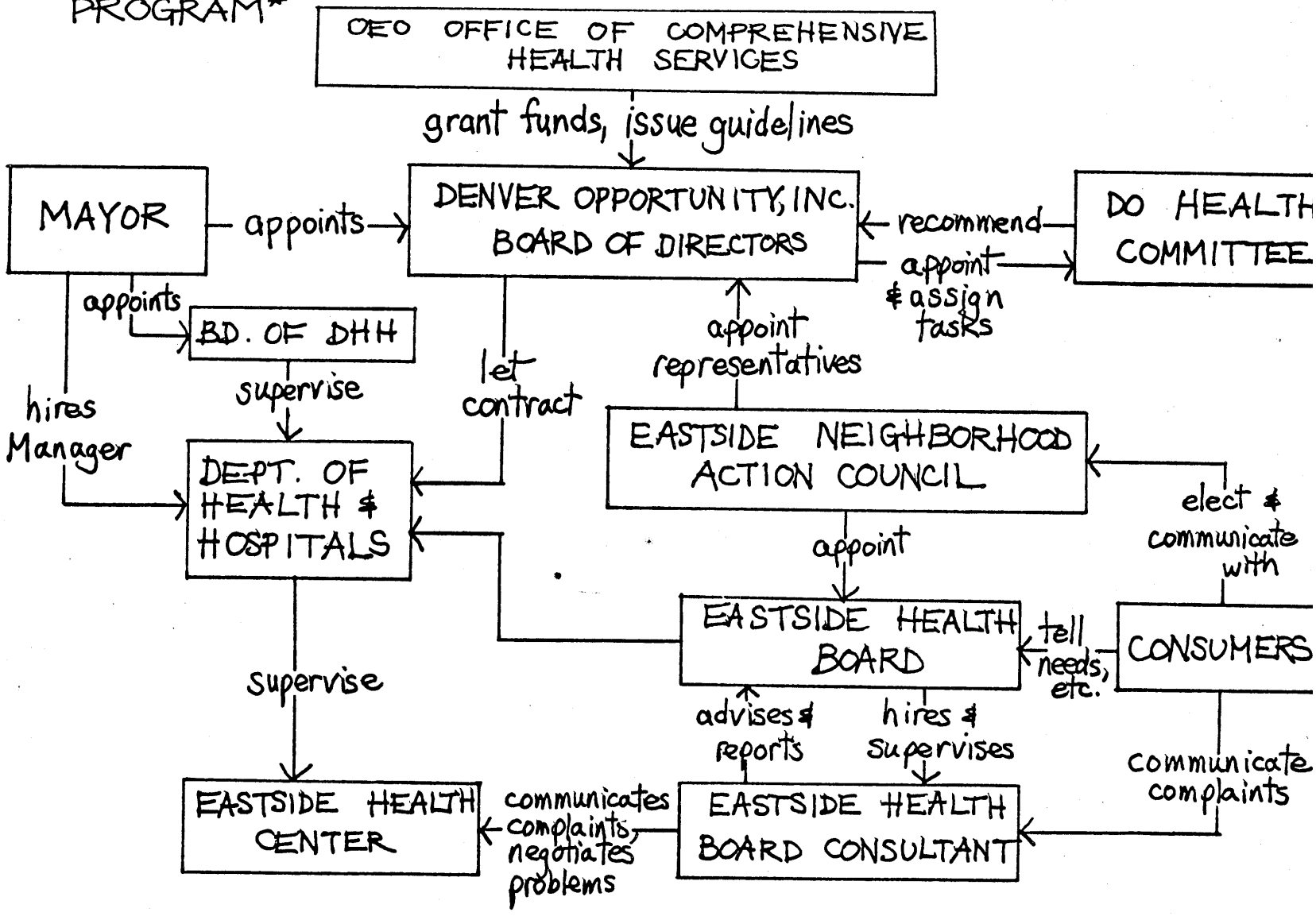
[6]Collins, op. cit., p.103.

FIG. VI-3: ORGANIZATIONAL RELATIONSHIPS, NEIGHBORHOOD HEALTH PROGRAM*



* The lines indicate the more important flows of authority and communication. All lines are in fact two-way, but the dominant directions are noted here. The chart emphasizes formal relationships. Some important informal ones are ommitted.

two Health Boards--Eastside and Westside--which are appointed from the members of the local Neighborhood Action Councils, smallest planning and operating units of Denver Opportunity, Inc. The Health Board Structure was approved by the DO Board of Directors in December 1967, shortly after the election of the first Neighborhood Action Councils. The Structure has been in operation since that time. The one exception has been that the provisions dealing with membership did not come into effect until the second election which was delayed until the fall of 1969, over a year late according to the provisions of the Structure.

The Structure dictates that each Board be composed of 20 members who are "appointed by Action Council Chairmen elected to such offices following each annual Neighborhood Action Council election."[7] The Eastside Action Council Chairman appoints 18 members to the Board. The North Denver Action Council Chairman appoints the other two members. Seven are current, elected members of the Councils. Of the other 11, not more than 4 may be representatives of agencies or organizations. It is specified that a member "continue to serve until his successor is appointed."[8] This provision accounts for the unanticipatedly long duration--over two years--of the first Board's term in office.

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[7]Denver Opportunity Board of Directors, "Health Board Structure," December 7, 1967, Sec. 1.3.

[8]*Ibid*, Sec. 1.5.

The Board is empowered to adopt its own bylaws and rules of procedure, and to create special committees. Designated Standing Committees are Executive, Personnel, Finance, and Planning.

Each Board has "in consultation with the Department of Health and Hospitals, the power to approve the Project Administrator [of the Health Center]," including authority to suggest candidates.[9] It has "the power to recommend administrative policies, in conjunction with the Project Administrator."[10] A procedure for appeal to DHH and to the Board of Denver Opportunity is specified, to be followed if the Health Board's recommendations are not implemented. The Board

> has the duty, in conjunction with the Health Board Consultant, to maintain appropriate rapport between staff of a Health Center and the Poverty community to the end that maximum utilization of the Health Center facilities will be achieved and in conjunction therewith, it shall be the duty of the Board to initiate a comprehensive program of planning to facilitate the efficiency of the Health Center.[11]

An especially important provision of the Structure during the tenure of the first Board was the responsibility of the Board to review applications for the position of Neighborhood Aide.

The Board is empowered to hire a Health Board Consultant to be the general administrative officer of the Board, "responsible

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[9]Denver Opportunity Board of Directors, op. cit., Sec. II. 8.

[10]Ibid., Sec. II. 9.

[11]Ibid., Sec. II. 10.

for and to the Board for implementation of Board policy."[12] He has offices in the Center and serves "as liaison for the Health Board and the poverty community with the Department of Health and Hospitals, the Project Director, and the staff of Denver Opportunity."[13] He receives and processes patients' complaints and grievances. He submits a monthly report to the Board on expenditures of funds through the Center and on its overall operations. The specified qualifications for the job include a preference for ability to speak Spanish as well as English. In addition,

> He shall have demonstrated some ability to communicate with and for the poverty community. He shall have demonstrated by past association, employment or otherwise, sympathy for the aspirations of the indigenous poor.[14]

The Health Committee of DO is listed as "the instrument of liaison between the Health Boards and the Board of DO."[15] Power to review the Health Board Structure and to initiate needed changes is vested in the Board of DO.

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[12]Denver Opportunity Board of Directors, op. cit., Sec. III. 1.

[13]Ibid, Sec. III. 3.

[14]Ibid., Sec. IV. 6.

[15]Ibid., Sec. V. 2.

DEVELOPMENT OF THE NEIGHBORHOOD HEALTH PROGRAM AND CONSUMER PARTICIPATION

The development of formally structured consumer participation in planning and running the Eastside neighborhood health program divides roughly into three sequential stages: (1) An advisory board organized by DHH, followed by (2) An advisory board with greater powers composed of members of the Action Councils of Denver Opportunity, Inc., selected in the first election to those neighborhood units, and then (3) An advisory board of Action Council members selected in the second DO election. The new board rejects the advisory role and demands control over, rather than merely participation in the neighborhood health program.

During the period when the first rudimentary consumer advisory group was operating, DHH was drafting a proposal to expand the neighborhood health program. This projected growth aroused strong opposition from the established medical community. The tenure of the first elected Board included a struggle within DHH over reorganization of the Department. Consumer involvement in planning the health sections of the local Model City Program which began in 1968 provides an interesting contrast to the experience of the neighborhood health program.

OPPOSITION IN THE MEDICAL COMMUNITY

As consumer involvement was just beginning to make itself felt in the Eastside Health Center, part of the medical community voiced vigorous opposition to the neighborhood health program.

Implementation of the program had lead to the resignation of Dr. William M. M. Robinson, Director of Denver General's outpatient department. He quit because he opposed the new program's "disregard of our charity efforts at the hospital and the adoption of this net approach instead."[16]

The politically volatile nature of the program was demonstrated when DHH aroused the ire of part of the medical community and established social service agencies by seeking to establish a second health center, to be located in the Westside section of the city. Dr. Daniel Benedict, the Denver Medical Society's representative on the board of the Denver War on Poverty and chairman of its health committee, charged in June 1966 that the neighborhood health center which had opened a few months earlier was a bureaucratic boondoggle. He suggested that it would be more effective to use public money to improve existing clinics rather than to extend the program as Dr. Cowen was proposing. Dr. Benedict claimed that the 11,000 visits to the Eastside Center made during its first weeks of operation had cost an average of $80 each.[17]

Later that month, the Health and Hospitals Board rejected the Department's extension proposal by a 3-2 vote. The DHH Board felt that the proposal was not properly presented. They expressed resentment at being asked to pass on a matter "already out of our

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[16]Charles Walter, "Anti-poverty Medicine: Another Big Sleeper," Medical Economics , Vol. 43 , No. 49 (Nov. 14, 1968), p. 208.

[17]Denver Post, June 12, 1966, p.20.

hands." Shortly thereafter, the Board reconsidered its negative vote and supported the new application. The Board seemed to have been at least partially convinced by the consideration that federal funds currently available might not be in the offing a year hence and were concerned that placing a center in the predominantly Mexican-American Westside was necessary to balance the services being given to blacks on the Eastside through the Health Center there. During the debate, another Board member Dr. J. Philip Clarke explained that many private doctors were concerned about the neighborhood health center. Physicians were not worried about the effect on their practices, he claimed, but had philosophical objections to the program.[18] Dr. Frank Candlin, one of his colleagues on the Board, argued that the neighborhood health program was just another step toward socialism. He declared, it is " unbelievable to think that the centers are not going to hurt the private practice of a physician ... When we reach center No. 25, there won't be any private practice."[19]

Medical Society President Dr. Clyde Stanfield sent a letter to his membership calling the proposed extension "premature." He charged DHH with failing to consult with affected health facilities and talent, and claimed that the proposal made commitments of doubtful legality and uncharted fiscal consequence. He argued that

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[18] Denver Post, July 22, 1966, p.10.

[19] Ibid.

the program was badly planned and lacked proper coordination with existing health and welfare offices.[20] Deputy Manager of DHH Phil Frieder, replied, "They're about 40 years behind the times, opposed to just about everything."[21]

Denver delegates to the 1967 Congress of the AMA House of Delegates complained to that body that funds for the neighborhood health program were applied for without consultation of the Medical Society. The charge was denied by the Dept. of Health and Hospitals. A Denver Post editorial praising the Health and Hospital's eventual reversal of its original negative vote commented,"Some have opposed the extension because that faction of the Denver Medical Society which always opposes new developments in medical care has opposed this one also."[22]

By December 1966, the Medical Society finally did endorse the $3.4 million DHH request to OEO for the 1967 program (including the new center), but with firm reservations. They stated that numerous private agencies were doing a good job of serving the needy and that under the program's definition of low-income families, approximately one-half the population of the whole city would be eligible for free care. Dr. Samuel Johnson, director of the program, declared that Health and Hospitals had extended a blanket invitation to private agencies to be involved in planning the program, and disputed the claim that the program would cover 50% of the city's population,

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[20] Rocky Mountain News, December 12, 1966, p. 65.

[21] Ibid.

[22] Denver Post, August 28, 1966, p. 2E.

saying that 20% was a more accurate estimate.[23]

Approval of the Denver Opportunity Board for the proposed expansion of the neighborhood health program was secured although that agency had received letters asking that their decision be deferred until "certain procedures were changed and the worth of the first center fully evaluated."[24] Opponents putting themselves on record included the Metropolitan Denver Dental Society, the Denver Area Drug Association, and Family and Children's Services of Colorado.[25]

By the middle of 1968, with the program expanding and its success secured, Medical Society opposition had all but died out. A Society spokesman was quoted as saying,

> Now we are trying to reestablish rapport with the health department. We need to talk again. That went out the window -- the reason we had such a hassle over the program.[26]

Local doctors found that the centers did not lure away their patients.[27]

When asked to explain the disappearance of Medical Society antagonism to the program, Cowen explained:

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[23] Denver Post, December 18, 1966, p. 44.

[24] Rocky Mountain News, December 14, 1966, p.8.

[25] Ibid.

[26] Insert accompanying Collins, op. cit., p. 104.

[27] Walker, op. cit., pp. 208-9.

> We didn't go away. I kept coming to their meetings. I invited them to vote me out, but they never took me up on it. It's hard to beat success. Also the Society has changed through exposure to us and a new generation of doctors. I serve on some fairly potent committees in the Society now. I'm what you'd call an "accepted bastard" I guess.[28]

There was no direct communication between medical and professional critics of the neighborhood health program and the nascent consumer organization attached to the Eastside Center. The charges of organized medicine were handled entirely by the administration of DHH. It is interesting to note that the emerging role of consumer participation at this time was not a part, at least not an important feature, of medical professionals' criticisms. Overcoming the opposition to the program from within the medical profession proved to be an indirect first step toward permitting the development of consumer involvement in the program. In defeating the challenge from the most powerful professional group involved, DHH in effect opened the door for broader consumer participation. There was no confrontation between outside professional demands and consumer demands. The two were separated in time. But the defeat of traditional views of medical practice was an integral part of a broader trend of change in the delivery of medical care. The more recent consumer demands are a later stage in the unfolding of that same thrust for reform.

The first stirrings of consumer participation were just beginning during this early period when professionals' opposition

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[28]Personal interview with Dr. David L. Cowen, Denver, April 8, 1970.

dominated public controversy over the program. The initial organization of consumer involvement in the program occurred through the creation of a lay advisory board.

THE LAY ADVISORY BOARD

An advisory group for the Eastside Health Center was organized by the DHH in late 1965, a year before OEO issued guidelines requiring formation of such committees. Dr. Arthur Warner, former Director of Maternal and Child Care for the program, explains that the "first fumbling board" was organized from residents of the immediate neighborhood of the Eastside Center.[29] A community organizer was assigned to seek out interested residents and to bring them together as a committee. She signed up members wherever she could find them. The body was composed largely of opportunists, "people who saw dollar signs." A large proportion of this group were the "agency poor"--persons already familiar with service agencies and active in their programs--no members of the truly hard-core poor.[30] One observor characterized the Advisory Board members, mostly black women, as "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."[31]

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[29]Personal interview with Dr. Arthur Warner, Denver, April 9,1970.

[30]Ibid.

[31]Elinor Langer, "Medicine for the Poor: A New Deal in Denver," Science (29 July 1966), p.511.

The functions of the group were never clearly spelled out. Charles Tafoya, a member of the Lay Advisory Board for the last few months of its existence, and named later to be Chairman of the first elected Board remembers,

> In the beginning the delegate agency resisted any form of community participation. The proposal, the contract called for it, but Health and Hospitals had their own view of what it would be.
>
> They first committee was poorly organized, didn't function really. It didn't have regular meetings. They had no real purpose.[32]

The first hint of resident protest was voiced at a meeting of the Board on February 14, 1965. Clarke Watson, Chairman , distributed a press release announcing that members wanted a major share in all planning for the center and demanded a role in the hiring of all personnel. He declared, "It's not so much who's hired as how he's hired."[33] Watson claimed to have the backing of the regional OEO office in Kansas City. He had met with a regional representative of OEO earlier. A surprised Dr. Johnson urged Board members to stick to the business of community health and to stay out of "politics." He explained his conception of the Board as a neighborhood "sounding board," a liaison between DHH and neighborhood residents.[34] His idea of their functions amounted to their offering suggestions about appropriate hours of operation and what services

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[32]Personal interview with Charles Tafoya, Denver, April 13, 1970.

[33]Denver Post, February 15, 1966, p. 17.

[34]Ibid.

to include. Johnson's shocked response was prophetic of the current provider-consumer conflict. After the meeting, he was quoted as sighing, "I feel like a man who's fathered a horrible monster."[35]

This first confrontation about the prerogatives of consumer representatives signalled a continuing tension over the goals for consumer participation and the degree of control to be exercised by the representatives. It was an early, but isolated, expression of the dissatisfaction of some consumers with the modes of influence provided them by the Health Board Structure. This incident made it evident that the locus of decision-making power was as important as the content of particular decisions. A description of this initial period of implementation of the program concluded:

> 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 not 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.[36]

Another instance of conflict between providers and consumers was the composition of the first group of neighborhood aides hired to work at the Center. The aides were a group graduating from a Denver University training program. No organization wanted to hire

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[35] Denver Post, February 15, 1966, p. 17.

[36] Langer, op. cit., p. 511.

them very badly. The neighborhood health program needed subprofessional workers, and employed the group. Some Mexican-American residents charged that the aides were not poor enough, that this first batch had not been selected on the basis of need. They criticized the amount of training in nontraditional medical functions received by the aides and feared that the jobs were coopting neighborhood leaders, draining off pressures for change.[37]

The Lay Advisory Board operated sporadically and without clear direction for several months. Warner recollects that,

> In late 1966 the militants tried to take over and thoroughly scared the city. The committee stopped meeting. It was still self-perpetuating. The agency, which is politically responsible to the Mayor, turned off the meetings.[38]

At this point, DHH moved to reorganize the Board according to OEO's new guidelines which required election of a representative body of consumers. This new group was the Eastside Health Board. With the establishment of a second neighborhood health center, the Westside Health Board was added.[39]

THE FIRST EASTSIDE HEALTH BOARD

Experience of the Board, Fall 1967 to Fall 1969

The performance of the first Board composed of elected representatives of the community is characterized as smooth and

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[37]Langer, op. cit., p.511.

[38]Warner interview, April 9, 1970.

[39]This case study focuses almost exclusively on the experience of the Eastside Health Board. In some instance, the two Boards have acted in concert, so the Westside Board will be mentioned in the context of joint activities.

effective by all concerned, both health providers and consumers. Cowen and the Deputy Manager of DHH, Phil Frieder, describe their relationship with the Board as friendly, cooperative and constructive. During this period the Board made major contributions to the development of non-medical aspects of the program. They expressed keen interest in the tasks of recruiting paraprofessional staff, locating new facilities, and monitoring physical conditions at the Eastside Center. Since the program was expanding rapidly and was still relatively young, Board members had a variety of important functions to perform in getting the approach fully implemented. Both providers and consumers maintained primarily service, as opposed to power-oriented, goals for consumer participation. Consumers enjoyed a clearly defined measure of advisory authority and did not press forcefully for greater control over the program. There was no apparent gap between the formal structure of participation and the manner in which it actually functioned.

The first elected Board was more broadly representative than the earlier Lay Advisory Board. It included more men and more representatives of social service agencies. The members were more outspoken than the kindly ladies who were a majority of the Lay Advisory Board, but they were hardly militants. Deputy Manager of DHH Phil Frieder points out that the Board was not composed entirely of political moderates. The vice-chairman was a "chief lieutenant" of the Crusade for Justice, a militant Mexican-American group, and the others "were not exactly milquetoast."[40]

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[40]Personal interview with Phil Frieder, Denver, April 10, 1970.

Charles Tafoya, Executive Director of the Latin American Research and Service Agency, and former Chairman of the Eastside Health Board, states: "The Board I was on was pretty representative--all ethnic groups, but no militants as generally defined. But we could be just as firm."[41]

From his experience as former director of Maternal and Child Care for the program, Arthur Warner recalls the first Board"s contributions:

> They were relatively powerless. They were preoccupied with screening prospective trainees. They gave advice about hours, but rarely on the extent or depth of services. They did complain about shortages and waiting lists.[42]

On the more positive side, he describes aspects of the program attributable to the Board's involvement:

> Their inputs included telling us how large a facility the residents would go to comfortably. That's how we arrived at the model of 10-12 staff in a 4-5,000 sq. ft. facility. They lead to our choice of a remodeled house rather than a new building. They showed us how difficult it is for some to be convinced that any health care would be okay for them. They told us to be extra careful in our offerings so as not to increase residents' fears.[43]

The current administrators of the program vigorously applaud the assistance given by the Board during this period. Cowen has written that the Department regards "community involvement as

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[41]Tafoya interview, April 13, 1970.

[42]Warner interview, April 9, 1970.

[43]<u>Ibid</u>.

prerequisite to an effective program."[44] " I could spend half a day talking about the great value of neighborhood involvement in the program."[45] He admits having no idea of what it is like to be poor or to be black, and praises consumer participants' contributions in helping the program to develop methods of service which are congenial to patients and meet their real needs. Tafoya cites as major activities of the Board during this period hiring a Consultant and setting up his office, and establishing the various committees and a grievance procedure. Members helped with expansion of the program and the establishment of several new stations. Cleanliness of the Center was a recurrent matter of concern to the Board, but complaints on this matter were promptly corrected, Tafoya remembers.[46]

Once its success was assured, the program acquired plenty of supporters in the federal government. Of course, they have had a succession of conflicts with federal representatives over the years. One which caused the program administrators and the Eastside Health Board to work hard together was OEO's requirement in late 1968 that the Department revise its fee schedule so that more patients would have to pay for services, and setting a ceiling above which families would be denied health care from the public system. After prolonged argument and lobbying, Denver was allowed to give free care to a family of four making up to $3,600. They had been giving free services to a family of four earning up to $6,700, which they considered to be a more reasonable indication of

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[44]Cowen, "Denver's Neighborhood Health Program," p. 1029.

[45]Cowen interview, April 8, 1970.

[46]Tafoya interview, April 13, 1970.

medical indigence.

In addition to their participation in the effort to convince OEO to change the new eligibility criteria, James Chavez, Eastside Health Board Consultant, cites as prime examples of recommendations made by this Board their personnel policies, development of the food supplement program, selection of sites for new stations, and getting DHH to contract out for manufacture of dentures so that the waiting time for acquiring these appliances would be reduced.[47] One example of a personnel question which they Board considered:

> When an individual was fired for excessive use of leave time, the Board investigated and recommended that she be reinstated with certain conditions. Health and Hospitals rehired her with those conditions.[48]

Chavez takes a broad view of health care and the objectives of the Center:

> You can look at health in terms of just medical technology or you can look at the social questions as well. When an individual comes in here without a job, I think of how that affects his health. If you're out of work, you have no money for food and you're more likely to get sick. If there are no jobs here, I contact individuals in employment agencies. This is all part of health.[49]

Warner sums up his view of this period of consumer participation in the program:

> The city ... wanted to satisfy the letter of the law and still not really deal with resident input. They went the "keep the water smooth" route.[50]

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[47]Personal interview with James Chavez, Denver, April 13, 1970.

[48]Ibid.

[49]Ibid.

[50]Warner interview, April 9, 1970.

Consumer participation through the employment of neighborhood residents

An additional means of consumer participation especially significant during the tenure of the first Board was the employment of residents of the poverty area by the health program. Many Neighborhood Aide jobs carry duties similar to those asked of consumer representatives: encouraging utilization of the Center, educating residents about health and making the Center responsive to consumers' needs. As neighborhood residents, one would expect these workers to express the needs of their neighbors within the organization. Some of this has undoubtedly happened. But Neig hborhood Aides has adjusted to the program in different ways. The literature on new careers has dealt thoroughly with the proposed tendency for subprofessionals hired from the neighborhood to lose their identification with their neighbors and to function according to a professional orientation which washes out potential communications they might make of neighborhood needs and desires.

The Neighborhood Aides performed a wide variety of functions. They worked with all phases of the program. The role which complemented most closely the activities of consumer representatives was that of "neighborhood representative." The neighborhood representatives were a departure from the traditional concept of the indigenous nonprofessional anti-poverty employee. "Unlike the nonprofessionals, representatives are not closely supervised nor are subprofessional tasks imposed upon them."[51] The

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[51]James A. Kent and C. Harvey Smith, "Involving the Urban Poor in Health Services Through Accomodation--the Employment of Neighborhood Representatives," American Journal of Public Health, Vol. 57, No. 6 (June 1967), p. 998.

representatives were trained to "solve other problems of a more immediate nature, which may act as barriers to the clients' use of health services."[52] They were supposed to give assistance on whatever pressing personal problems a potential patient of the Center had.

James A. Kent, head of the program's behavioral science unit, concludes that Aides assigned to the Centers were "thoroughly contaminated" after about six months.[53] He and some of his colleagues fought to have the Aides who were assigned to be neighborhood representatives work out of their own homes and to be supervised by the health educator on the staff. They felt that this practice would keep them in touch with their neighbors and would prevent the representatives from identifying so closely with the Center that they would no longer effectively advocate patients' interests. Instead, the social workers in the program succeeded in basing the neighborhood representatives in the Centers, under social worker-' supervision. Kent, a firm believer in the neighborhood representatives idea, laments:

> Those idiots didn't understand the concept. The poor are very delicate people. You can't step on them. They are so grateful for a job. Their vulnerability is exploited. It's a real con job. They're subverted, conned into being a social worker in attitude but without the actual status.[54]

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[52]Kent and Smith, op. cit., p. 999.

[53]Personal interview with James Kent, Denver, April 13, 1970.

[54]Ibid.

Near the beginning of the program there were over 200 Neighborhood Aides in training at one time. The Health Board screened over 1,000 applicants for the jobs, a task which DHH feels they performed superbly and which Board members identify as one of their most important responsibilities.

The Reorganization Struggle

In August 1968, DHH Manager Dr. Cowen and his Deputy Phil Frieder announced that the neighborhood health program would be removed from the Division of Public Health and Preventive Medicine and placed under the immediate direction of the Manager of DHH. Their stated purpose for taking this action was to improve the administration of the program. By making it directly responsible to the Manager rather than the responsibility of one of the several operating divisions, as had been the case, they sought to better coordinate the efforts of the different divisions as they related to the program. Supposedly, the program had had trouble acquiring the full and speedy cooperation of other divisions when it was needed.

The announcement of reorganization incurred immediate negative reaction by the administrative staff of the program, employees of the division of Public Health.

Dissident staff members forced release of a report written by Dr. Robert Ferguson for Systems Development Corporation on the organization of DHH. The report turned out to be critical of all parties to the disputes. It recommended strengthening the role of the Manager, observing that at the moment ultimate authority for

general politics and decisions was vested in the office of the Deputy Manager, bypassing, Samuel Johnson, head of the Division of Public Health. Ferguson observed that the Manager preferred not to deal with details and that the Deputy Manager did. The report argued that the responsibilities assumed by Frieder restricted the amount of time he could devote to long-range planning and development, community relations and fiscal management. The report was also critical of the research and program development section, charging that they collected data for reports rather than doing basic research and evaluation. The administration was characterized as operating as a closed shop. Low level managers lacked sufficient authority to act on their own.[55]

In effecting the reorganization Cowen and his aides chose to accept portions of the Ferguson Report and to reject others. They centralized administrative authority and streamlined operations, but failed to restructure the responsibilities of some of the key administrators as the report had recommended.

The program's approach to consumer participation was part of the conflict, but only one of a whole set of interrelated issues. Many of those opposed to the reorganization advocated stronger advisory roles for the Health Boards. This was not an immediate point of contention, however, because consumer representatives themselves were not yet demanding greater power. The public health division administrators' advocacy of aspects of the program which they felt fostered consumer participation, both through representation and through informal mechanisms, did conflict

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[55]Denver Post, September 13, 1968, p. 4.

with the standards of efficiency and tighter management articulated by Cowen and Frieder. The former administrators of the program saw small health stations as essential to encouraging active use by the poorest residents of the area. They felt that the reorganization would threaten the program's flexibility to respond to important differences among the neighborhoods served by different stations. They believed that reorganization would stifle progress toward increasing consumer participation in running the program.

A group of eleven professional staff members (from Public Health and other divisions) who opposed the reorganization scheme organized into a committee which met frequently to discuss their reactions and to express their opposition jointly. When the disagreement became front page news, Cowen fired Johnson, who had started the neighborhood health program, for "flagrant violations involving unsatisfactory performance," insubordination, unauthorized absences and "acts detrimental to the good of the service."[56]

Johnson was a brilliant innovator who had gathered a staff of highly talented, imaginative and deeply committed individuals to run the program. His and their strengths lay in their capacity to conceive of new approaches for delivering health care, to elaborate these concepts and to implement them. They successfully sought the support of funding sources, professional staff and client communities. When their bold ideas and approaches

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[56]Denver Post, September 13, 1968, p. 4.

began to be implemented, the administrative challenges shifted from the requisites of refining and selling innovations to the hard, dull realities of constructing and maintaining effective management routines. Local participants on both sides of the dispute admit that Johnson was not a skillful administrator.

Arthur Warner, Director of Maternal and Infant Care for the program, was given a 30-day suspension for insubordination expressed by publicly opposing the planned reorganization. Warner is an easy-going, open man who does not enjoy conflict. He had strong rapport with DHH staff members and worked effectively with consumer groups. It is difficult to envision him as being guilty of malfeasance of any sort. His suspension drew particular criticism from DHH staff members.

Mayor Thomas Currigan backed up Cowen, ruing the "slippage" that had occurred in the program during the last year.[57] Johnson refused to resign. He and Warner sought and obtained a temporary restraining order on the reorganization and the loss of their jobs on the grounds that DHH had not first secured the approval of the federal agencies funding the program. Three consumers of the program who were not on the Health Board tried to file an intervening suit in support of Johnson and Warner's motion.[58]

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[57]Denver Post, September 13, 1968, p. 4.

[58]The judge did allow intervening suits by the Core City Ministry and a group of doctors, but not from the trio of consumers.

Before the issue came to trial, Johnson and Warner agreed to submit the dispute to arbitration. The resulting agreement let the reorganization proceed as planned, but gave Johnson new responsibilities and rehired Warner. They and several other opponents of reorganization left a few months later since their reorganized roles seemed meaningless and their disagreements with the new direction of the program were irreconcilable.[59] Some of them returned to academic posts, some found work with health programs and anti-poverty agencies in other cities, and a couple stayed in town to found the Foundation for Urban Neighborhood Development, a consulting firm specializing in community organization.

James Kent, author of the dissident eleven's position paper, claims that the key issue at stake was whether a group of "untrained politicians" should be allowed to take over the program.[60]

In a letter to the Post, one of the eleven, H. Hechter, wrote,

> The current controversy is another episode in a long standing clash between political lackeys and dedicated professional workers who are concerned with implementing quality medical care ... .[61]

In fact, Cowen is highly trained and hardly a political creature in the traditional negative sense. The ideological differences run much deeper. The staff members' opposition was based on basic

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[59]Kent interview, April 13, 1970.

[60]Ibid.

[61]Denver Post, September 14, 1968, editorial page.

differences about objectives for the program and what methods were appropriate for carrying them out. Kent sees health as a potential agent of broader social change, not just a service. The administrators of DHH are committed to a service model.

A poignant expression of his broader objectives for the program was voiced by Kent in a letter to the editor:

> The tragedy is that the so called liberal leaders on the Board of Health, in the political structure, and in key pressure positions have behaved as though Rome was not burning. These liberals should be aware that their time is coming to an end. A new political coalition is arising out of the frustrations of dealing with a non-responsive city government.[62]

In other words, provision of good health services is not enough in itself. The health program needs to address larger social and political issues and provide a vehicle for grappling with them.

Although the issue was that of which persons within DHH would have operational control over the neighborhood health program, the Eastside Health Board took a neutral position on the reorganization question. Chairman Charles Tafoya comments, "We saw it as an internal matter."[63] Warner characterizes the Board members as "vendidos" (sell-outs) because they failed to see how the reorganization subverted consumers' interests.[64]

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[62] Denver Post, February 28, 1969, p. 21.

[63] Tafoya interview, April 13, 1970.

[64] Warner interview, April 9, 1970.

The Board's neutrality may also have been caused by the fact that the impacts of reorganization were not visibly apparent or immediately significant. Services continued to be delivered. In fact, it is hard to pin down what is different as a result of reorganization. Kent mentions as one loss the original administrators' plans to hand control of the neighborhood stations over to local neighborhood corporations. The most recent new health station departs from the model of a natural neighborhood focussed station which he advocated. He adds, "The two Centers have gotten more like Denver General in their management."[65] Bernard Karshmer, present Administrator of the neighborhood health program, comments

> There were administrative problems, especially at the stations. My predecessor had a much looser theory of administration than I do. He believed in natural leaders and in permitting a great deal of decision-making freedom at each station. It's a nice idea, but resulted in a good deal of chaos.[66]

Karshmer believes in tight administration, but he is hardly a cold organization man. He joined the DHH staff in 1968 after acquiring a degree in business administration. He thoroughly enjoys his work and is good at it, commanding respect and also affection. His administrative firmness belies a very informal and warm personal manner. He is fervently committed to better health care for the poor and shares many of the goals for broader community

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[65]Kent interview, April 13, 1970.

[66]Personal interview with Bernard Karshmer, Denver, April 10, 1970.

control expressed by the new Eastside Health Board. He sees the benefits of reorganization as smoother operation of the program and better coordination with other departments of DHH.

Frank Woertman, administrator of Project CHILD and Maternal and Infant Care and signer of the position paper drafted in opposition to the reorganization, was later asked to resign and refused. He was subsequently fired and appealed to the Career Service Board. At the hearing Karshmer and Cowen charged that the centers were in a mess. The Board concluded otherwise, stating that the centers were part of a "pioneering and innovative program which has accomplished great good in the fields of health and preventive medicine for the people of Denver."[67] After a four-day hearing, longest in their history, the Board granted Woertman's appeal:

> The Board finds that the evidence shows that the thirty-day notice of dismissal and the discharge of Mr. Woertman were part and parcel of a systematic program to force out of the Department of Health and Hospitals those persons, including Mr. Woertman, who signed Exhibit A., the Position Paper of September 6, 1968, in response to the reorganization of the Department of August 22, 1968.[68]

Two former DHH employees who left during the reorganization conflict--James Kent and Sam Burns--stayed together to pursue the kind of work they were doing with the neighborhood health program. They formed the Foundation of Urban Neighborhood Development (FUND) to undertake projects which are highly relevant to the history of

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[67] Denver Career Service Board, "In the Matter of the Appeal by Mr. Frank J. Woertman, Findings and Order," May 20, 1969, p. 3.

[68] *Ibid.*

the neighborhood health program because they demonstrate in concrete terms the kind of vision these men had for the program. Their experience and writing are doubly germane because Kent had the responsibility when he was with DHH of helping the program staff to "redirect their philosophy toward the urban poor. He operated as the interpreter and advocate for the urban poor in Denver."[69]

In the early stages of the Denver program, it was consumer-oriented professionals like Kent who demanded participation for the poor more vigorously than any other group including the medically indigent themselves. The political philosophy of consumer involvement of this group is directly counter to that of Cowen, Frieder & Co. Kent, Burns and the program's former health educator, Harvey Smith, held these objectives more strongly than others on the staff of the neighborhood health program, but many others tended toward or sympathised with their beliefs and approach. FUND's credo is in many ways the conceptual opposite of the present governing philosophy of the program. The difference is expressed succinctly in one of their recent grant applications:

> FUND is committed to the development of local people who can generate their own theories and programs of change and social movement. Decentralized, action-oriented education based on the cultural characteristics of a natural population is basic to achieving change within that population.[70]

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[69] James A. Kent, "The Death of Colonialism in Health Programs for the Urban Poor," unpublished paper, June, 1969, Forward.

[70] Foundation for Urban and Neighborhood Development, "Toward Indian Control of American Indian Education, A Proposal for a Demonstration Project," Denver, mimeo, January 1970, p. 1.

Consumer participation is pursued through the mechanisms of formal representation, but unorganized, unrepresented groups--the "powerless poor"--are involved through informal networks of natural leaders brought into the program to strengthen those contacts and to translate them into an avenue of entry for the nonparticipating poor. ("Nonparticipating" is used here in the sense of not using services, not availing one's self of the facilities available.) FUND considers these to be issues which must be dealt with successfully before worrying about involving the powerless poor in planning or running the program itself. Their approach to participation is developmental. Residents are trained to enable them to successfully progress from powerlessness to mastery of their individual needs, to small group involvements, to participation in larger groups concerned with effecting social change. This contrasts sharply with the DHH focus on consumer participation as a mechanism of representation, a management problem and a vehicle for improving the program as a whole. Kent and his colleagues emphasize the benefits to individual participants--their personal growth--and therefore are interested in a variety of contexts for participation much broader than the Health Boards alone.

The same FUND report quoted above underscores this emphasis on development as opposed to representation:

> The War on Poverty is legendary for turning over control of programs to the so-called local poor, only to find that the powerless or chronically poor simply had new masters--the powerful poor.

> When control comes without preparatory development, however, the poor are caught with a knowledge of only the previous programs (which have exploited them).[71]

The powerful poor--Board members, for example--behave as the previous insensitive people did, therefore the program fails. Consequently, people in the dominant society say, "See, self-determination really doesn't work."

Kent speculates today that perhaps the formal mechanisms with which we have saddled consumer groups are doomed to failure. He does not have a prescription for change in this regard--the more "natural" form could be any of several possibilities--but he argues that the consumers, the powerless poor must be helped to discover this for themselves.

The deposed originators of the neighborhood health program are particularly disappointed at the turn it has taken away from the small stations which feed into the two larger centers. The original theoretical rationale for the size and location of these stations focussed on the concept of natural area, of station size related to what consumers, particularly those with limited prior contact with outside institutions, would feel easy in approaching and using. Karshmer explains that the smaller centers have turned out to be too inefficient. There were problems of station staff morale, and any staff absences make it very difficult to render a complete range of services on a given day.

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[71]Foundation for Urban and Neighborhood Development, op. cit., p. 6.

THE NEW EASTSIDE HEALTH BOARD

In October 1969, residents of the Denver Opportunity target areas elected new members to the five Action Councils. Only a few incumbents were elected. No members of the first Eastside Health Board stood for reelection. Charles Tafoya, Chairman of the Board during its initial two years of functioning, explains that the members felt that they had served the community for a considerable period of time and were anxious to have others assume their duties.[72]

The election campaign sported some fiery statements by individual candidates, but attracted relatively little interest in the poverty neighborhoods, except among persons regularly associated with anti-poverty program activities. The Action Council areas were divided into varying numbers of districts which elected representatives to the individual Councils. In a few of these subdistricts, voter participation approached 10% of those eligible, but in most the turnout was much lower. Denver Opportunity, Inc., and Action Council spokesmen expressed disappointment over the lack of broader participation in the election and offered a variety of explanations for the turnout: insufficient resources for planning and publicizing the process, the absence of more burning issues, neighborhood apathy, and the unique and unfamiliar nature of an official election occurring outside the auspices of the regular governmental election process.

The Eastside Neighborhood Action Council elected Frank Bailey, a strong black militant, as its Chairman. The majority of Action Council members had had extensive previous experience with local

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[72]Tafoya interview, April 13, 1970.

anti-poverty activities and politics. Several of them were employed by Resident Participation in Denver, Inc., the local Model Cities vehicle for citizen participation, and by other anti-poverty organizations. Bailey appointed a new Eastside Health Board which was considerably more militant than its predecessor. The new members departed abruptly from the quiet relationship enjoyed previously by DHH and the Health Board.

In what DHH calls a "premature" meeting (according to the Health Board Structure, the new Board should not have taken office until a month after announcement of the election results) on October 31, the Board called for the resignation of Frank Justice, white administrator of the Eastside Center, and his administrative assistant Dan Euell. The following week, Board Chairman Wesley L. Mack read a list of 19 deficiencies which members had found in the Center during an inspection undertaken October 31. They cited overflowing trash containers, lack of employee supervision, doctors not working and refusing to see patients who were late for appointments and unsanitary conditions.[73] Frank Bailey reported finding 277 appointment reminder cards addressed, but thrown out and never mailed. Justice replied to these charges that a new system had been instituted for handling tardy patients and for reminding patients of appointments, that a new housekeeping administrator had been hired to improve maintenance, and that remodeling following the unsolved bombing of the Center

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[73]Denver Post, November 9, 1969, p. 61.

five months before had made cleanliness harder to achieve. He commented that recruiting medical personnel to work at the Center would probably be made harder as a result of this controversy.[74]

Cowen acknowledges that there was justification for some of the Board's complaints. He points out, however, that a great many of the problems "stem from the Center's success: the large number of patients who use it" and exceed its capacity by a factor of two.[75] He adds,

> One complaint had to do with dirty words written in the women's john. [Justice] can hardly be held responsible for that.
>
> My response has been, let's pinpoint the problems and try to solve them. If we can't and the reason is a person, let's work with him.[76]

Board Chairman Wesley Mack is a lifetime resident of the Eastside. He has been active in a host of community organizations for years, including many projects to improve recreation opportunities for area youth. He is a firm, dedicated man who projects none of the smooth rhetoric of some professional consumer representative leaders.

Mack notes shortcomings in the Center's organization and physical plant when asked to detail the Board's demands. The demands are for "adequate space, doctors and conditions."[77]

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[74] Denver Post, November 9, 1969, p. 61.

[75] Cowen interview, April 8, 1970.

[76] Ibid.

[77] Personal interview with Wesley Mack, Denver, April 14, 1970.

He mentions the need for resting areas for doctors, for air conditioning, less crowding in the waiting room and the area around the pharmacy window:

> Bumping has happened, with bottles broken and then the person has to have the prescription filled again. Upstairs the higher administration have spacious rooms. There is a conference room which I haven't seen used much. It's unnecessary.[78]

He suggests that the downstairs be used for treating major ills, upstairs for dentistry and pediatrics, and expanding onto the third floor to relocate administration. The fact that the third floor is still apartments, he cites as another inadequate condition. "It seems like they're nonchalant because it's a black area."[79] Mack declares,

> We know that a new Structure will not amount to another way of operating ... . Health and Hospitals say they're interested in participation, but they put people up as puppets. They want to monitor. All we're saying is let's run the country the way it's supposed to be.
>
> People turn to Washington, but don't get any results. People here want to do violence. I'm blamed by my own for not allowing it. I've been scorned and cursed at. I keep saying, "Let's do it the legal way, the right way." But it's hard when that doesn't work.[80]

It is interesting to note that the complaints expressed by the Board parallel the earlier consumer group's focus on the less

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[78]Mack interview, April 14, 1970.

[79]Ibid.

[80]Ibid.

purely medical aspects of the program. There is a picky, almost conservative ring to the list of grievances. On the other hand, the complaints provided a legitimate backing or clothing for the Board's demand that it be given ultimate control over the program. The list of complaints is a good illustration of how the demand for control is both instrumental (a way to insure a cleaner, more efficient Center) and an end in itself. The list is by now means a put on. The complaints were deeply felt, the specifics mentioned were highly symbolic of second-class treatment. However, they were easily remedied, as Cowen pointed out. Therefore, the demand for control per se had significance beyond the instrumental. It was a route to greater self-determination of the black community.

At the initial stages of this conflict, Eastside consumer representatives were clearly using their established channels and methods in trying to influence the program and to acquire greater authority over it. They were attempting to exercise influence through rational persuasion. As the conflict wore on, consumer representatives began to give up on rational persuasion and adopted a stance of protest and confrontation. Denied satisfaction through the sanctioned modes of influence available to them, they moved rapidly to a more coercive posture.

DHH administrators feel strongly that the new Board was picking a fight from the start. Their presentation of the grievances and demand that Frank Justice be removed as head of the Center were not friendly or polite. They were, however, significantly

more moderate in tone than the statements and tactics which were to follow.

The more aggressive demeanor of the new Board was due in part to the objectives and personalities of the individuals appointed to the body. However, their individual characters do not provide a satisfying explanation. Why did these persons stand for election and why were they elected? They and their supporters sought a modified way of doing things and were somewhat dissatisfied with the behavior of the previous Board. Judging from their conduct since taking office, the new Board seems to have sought power for its own sake, or at least for its potential uses beyond the governance of the neighborhood health program. They were motivated to run for office and to accept appointment to the Eastside Health Board by dissatisfaction with the performance of current social service programs, including health, but they were involved also because they held power-related goals for consumer participation. Community control of the neighborhood health program would be a means of building the political clout of the black community, of accumulating political skills and resources, as well as a route to improving the neighborhood health program itself.

The approach of the new Board was also strongly influenced by the stage of development of the program during which they entered the picture. If the previous Board had continued to serve, it probably would have proceeded in the tranquil fashion to which it was accustomed. The new Board members, however, had no personal

experience with the tasks performed by their predecessors, no sense of identification with the program based upon those contributions--contributions no longer required by the program, or else now handled efficiently by DHH administrators. The attitude of the administrators toward the consumer representatives was also changed by the evolution of the program. Because they had been dealing, in the case of the first Board, with consumer representatives from whom they had at first actually needed help--in interviewing applicants for paraprofessional staff positions, in promoting residents' acceptance and use of the services--DHH administrators were blinded to the painful implications of the program's maturation. The administrators were now necessarily more concerned with establishing and maintaining efficient management rountines, with sustaining federal funding and garnering positive evaluative of the program's results. The shifting requirements of organizational maintenance and enhancement made them rely less on consumer representatives at a time when national and local pressures largely separate from health care issues guaranteed the existence of a mounting demand for community control of the program.

Both sides in the conflict asked OEO to step in and settle the dispute. According to Cowen, OEO instructed the providers and consumers to redefine and reclarify the role of the health advisory board. He comments, "We have never treated them this way before," implying that their actual powers had exceeded mere

advice-giving previously.[81] He complained that it took the Board 45 days to produce a proposed new Board Structure. The City Attorney has outlined how the proposed Structure conflicts with the city charter and ordinances, therefore, Cowen argues that his Department cannot legally agree to the suggested arrangement. Cowen sums up the present Board's performance as follows:

> Except for some inadequate assistance, they haven't helped with the traditional function of helping us recruit trainees. ... They haven't screened anybody for the last three months. We have slots now that are not filled.[82]

The changes in the Health Board Structure demanded by the Boards spell out in detail the new way of operating which they seek. The proposed new Structure attempts to give legal definition to the new levels of authority desired. It narrows the gap between formal structure and the manner of actual functioning of consumer participation which they demand. By revising the current Structure, they try to make the transition from consumer participation to community control. The crucial difference between the two is obviously the locus of authority. The fact that the Board proposed a new Structure based upon the current document illustrates that community control is an extension of consumer participation.

In a backhanded, perhaps unconscious compliment to Frieder, chief designer of the original Structure document, the proposed revisions accept the basic structure of the document, leaving whole sections intact and amending language within the framework of the

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[81] Cowen interview, April 8, 1970.

[82] *Ibid.*

original document. Judging from the proposed revisions, the new Board is generally satisfied with the provisions covering membership, appointments and organization. They proposed substantial revisions in the area of duties, responsibilities and rights. They leave entirely untouched the duties and qualifications of the Health Board Consultant.

The administrators of Health and Hospitals might take some small solace from the fact that the militant consumers who seek to gain control of the program are committing themselves to living with large portions of the framework which has served the program well in its impressive development over the past two or three years. Of course, DHH administrators feel that the changes demanded are basic and potentially destructive. They see the changes as jeopardizing accomplishment of the goals--service goals--for the program. Nonetheless, the degree to which the would-be amenders adopt Frieder's language is striking. Another claim of the providers which must be lent some credence is that the consumers' Board already has shown a certain degree of disregard for the document, witness their premature meetings in the fall of 1969 and DHH's accusation that Board meetings have been held without legal quorums.

The proposed revisions mirror the demands made by the new Board which center on removal of the present Project Administrator, but they extend the sense of this demand and spell out the new mode of control they envision. The size of the Boards is increased

from 20 to 22, the additional members being medical representatives of Health and Hospitals appointed by the Mayor. Another proposal of conservative and cooperative complexion calls for the formation of a "Professional Medical Audit Committee which shall be selected from the appropriate medical societies of the City and County and the duties of said Committee shall be to evaluate the comprehensiveness of the treatment rendered to the patients at each Center" and to make appropriate criticisms and recommendations to the Project Administrator.[83] At the end of last year DHH established a Medical Audit Committee for each Center and a program of self-education for doctors. The Structure revision would form this group more along the lines of an outside examining committee.

The Board is granted the power to contract for neighborhood health services and to monitor performance of the contracting agency. It will determine, rather than recommend, administrative and fiscal policies. The Personnel Committee acquires the new duty of selecting nominees for the position of Project Administrator, the final selection to be made by a two-thirds vote of the Board. The position is exempted from Career Service requirements, a definite conflict with existing city statutes. The revisions add the specification that fiscal employees be adequately trained, certified and properly bonded.

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[83] "Health Board Structure," Westside and Eastside Health Boards' proposed revised version, mimeo, spring 1970.

The Board grants to itself complete control over the selection of sites for future Centers and satellite stations.

The draft of the proposed revisions as it read in April, 1970, made the final provision that nothing in the document be interpreted or implemented contrary to laws and anti-poverty agency regulations. The words "City ordinance or City Charter provisions, Career Service provisions" were striken out by hand, presumably after the Boards realized that their changes were, in fact, in conflict with existing local ordinances and the Charter. Health and Hospitals administrators cite this conflict with the laws of the city as evidence that the proposed changes are impossible. The Boards view this as a smoke screen and want to see the local laws changed if that is what is necessary to implement the new Structure.

The Board's approach of revising the Structure rather than starting from scratch presents an image of evolutionary transition rather than abrupt reversal of course. The Boards claim that their revisions are non-negotiable, but the most explicit statement of the changes demanded is in this framework of a legal document whose whole form provides opportunity for a bargained settlement. It would be surprising if this is not in fact the way the current conflict is resolved--that the Structure is amended in compromise fashion, probably through arbitration. In any case, it is highly favorable to the chances of successful negotiation of present differences that the consumers' demands

are expressed in so tangible a form.

There exists a striking gap between formal structure and actual functioning in the new Health Board Structure proposed by the current Boards. Their draft document both expresses what is actually happening in ways not covered by the structure presently in force and articulates desired changes of form and activity. It is a safe bet that the new form will not depict with complete accuracy the new way of operating which is emerging. Evidence the Boards' intention of retaining the role of the Health Board Consultant in its current form. The need for such a position was originally premised on the limited powers accorded the Board, for as long as their participation was advisory rather than controlling, there was a need for a liaison role. The various duties assigned to this role require an enormous amount of flexibility and skill to satisfactorily perform. The conception of this role in the original document is carefully detailed. James Chavez, Eastside Health Board Consultant, has consistently done the tasks asked of him in the structure and has remained in good communication with the several groups and levels of authority which relate to the Center. This is no small feat. It is difficult to tell how much of his success can be attributed to the imaginative structuring of the role, how much to the personal talents of the man who has held the job.

It is strange that a Board with the proposed new powers should feel a need for a Consultant with the same duties. Perhaps

they have not thought this through yet, maybe they do not want to do anything offensive to the person holding the job at present, whose contribution they respect. In any case, the emergence of a controlling Board would seem to remove the need for a Consultant in his present form. Under the revised method of operating, the Project Administrator would become directly accountable to the Board and responsible for handling complaints, submitting regular reports, and so forth.

The conflict over the extent of control to be exercised by the consumer representatives is accentuated by the shifting organizational requirements of the program and the Neighborhood Action Councils. By the fall of 1969, the program was solidly established. Many of the tasks which consumer representatives performed during the early stages of implementation were no longer necessary to the survival of the program or were being handled effectively by the program staff.

Cowen posits quite accurately that the possible functions of the Health Boards are limited: He cites two major ones: (1) to handle complaints of patients, (2) to develop new programs and to review the adequacy of existing programs. Less explicitly, he mentions another, (3) to assist in the ongoing operations of the center.[84] For example, to suggest and to implement ways to improve the rate of broken appointments. The handling of complaints has

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[84] Cowen interview, April 8, 1970.

been largely removed as a function, contends Cowen, because the Center is responsive to complaints and has taken corrective action on them. He seems to feel that the Board falls down in its performance of the second potential function or rejects it as an appropriate emphasis of their activities. What providers of health care have in mind when they refer to consumers reviewing existing programs and developing new ones is constructive criticism, not insistence on radical changes. What the current Board is demanding fits comfortably under this category of functions according to the Board's definitions. Health program administrators are generally uncommitted to presenting information to consumer groups about program operations and are unimaginative in the ways they attempt to do so. The Denver Health Boards receive monthly reports from the Consultants which could provide the basis for program reviews, but the reports do not excite much attention. This is not surprising because the monthly reports do not relate to pending decisions about the program.

However, Cowen has stated in one of his stronger expressions on the subject:

> community representation must be granted a reasonable function and responsibility. It is best expressed at the neighborhood level. Neighborhood Health personnel as well as personnel at every level in the whole Agency must be responsive to neighborhood needs and provide the neighborhood with information regarding future plans, present problems, needs and desires which the neighborhood people can help meet.[85]

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[85]David L. Cowen, "Health Administration: A National Frontier," p. 8.

Wesley Mack told an observer in April that the Board was not asking that Justice be fired, just that he be reassigned away from the Center. Justice took a three month's leave of absence for reasons of health during the controversy. When he returned he was assigned to other duties, but this action failed to defuse the situation or to pacify the Health Board.

In their Quarterly Report on the neighborhood health program for October-December 1969, DHH announced the election of new Health Boards and described their version of the events which followed. The account is very restrained, summarizing the course of communications and quoting from the demands of the Eastside Health Board. The report ends stating that "the DO Board decided that members should become familiar with the Health Board Structure--the document which governs the roles of the two health boards."[86] But on May 14, the DO Board voted to withhold its authorization of a contract with DHH for operating the neighborhood health program. The current contract expired December 31, 1969. Local leaders have sought assistance from OEO in resolving the deadlock, but the Office of Comprehensive Health Services insists that the dispute is a local matter which must be resolved locally. OEO has informed Denver Opportunity the funds will be held up until a new contract is signed.

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[86] Denver Department of Health and Hospitals, Denver's Neighborhood Health Program. The Quarterly Report, (October, November, December, 1969), p.19.

Bernard Karshmer is pessimistic about the current deadlock. He feels that some of the Board leaders are opportunists without strong commitment to good health care. He believes that the Board is not representative, "but we have to treat it as though it is."[87] He wishes others in the community would voice their opinions about the current conflict. He says with a great deal of feeling, "A lot of people get unhappy at the word, but I like the concept of cooperation--people sharing decisions."[88]

Cowen echoes Karshmer's point about representation:

> What we ought to be doing is developing structures so that there would be representation for all programs, there would be an election mechansim for representation of patients. This would apply to all components regardless of who had funded them. It's time to move to the next step in resident participation. Instead we have this fight.[89]

According to Kent, DHH is against the current demands of the Board because they are afraid:

> It's fear. They use money to stay in power. It's a power structure model. There'd be less power for the central group. If the economic power in the city gets spread out, the power structure can't run it so easily any more. Also, they're afraid that a resident-controlled center'd be damn successful.[90]

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[87] Karshmer interview, April 10, 1970.

[88] Ibid.

[89] Cowen interview, April 8, 1970.

[90] Kent interview, April 13, 1970.

The behavior of DHH administrators has stemmed from their strong service orientation. The following quotes from Dr. Cowen illustrate his service-related goals for participation:

> The two-way communication from the Establishment to the core city populace has been an education to say the least.[91]

> Recipients of our program have been most helpful to us in providing ideas, opening channels of communication. In other words, our patients are having a very positive impact on the total program.[92]

Daniel Smith, Chief of the Office of Consumer Affairs, OEO Office of Comprehensive Health Services, sees Cowen as insisting that one has to draw a firm line rather than allow continual extension of consumer controls and responsibilities, that "You can't open this door or there'll be no end to it."[93] Cowen has said:

> I also know there are many things the poor can't do. It's destructive to behave otherwise. You've got to hold on to certain powers in a program or it's not going to fly. You get into a conflict over whether you're interested in maximum feasible participation or in providing really quality health care...[94]

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[91]David L. Cowen, "Comprehensive Health Care and School Health Programs," Speech presented at the American Public Health Association Meeting, Detroit, Mich., Nov. 12, 1968. p.8.

[92]David L. Cowen, "Health Administration: A National Frontier," p.7.

[93]Personal interview with Daniel Smith, March 19, 1970.

[94]Cowen interview, April 8, 1970.

A second dimension of variation in objectives for participation is that of representation vs. development. The Health Board Structure expresses clearly and explicitly the goal of representation. The consumers on the Boards are expected to express consumers' interests vis a vis the program. The developmental approach, best articulated by James Kent and his associates, seconds the importance of formal representation, but stresses other means of consumer participation with the goal of helping powerless poor to learn to cope with immediate personal problems, then to operate in small groups, then to be part of larger organizations for social change. The approach conceives of each person using the program as a participant and seeks to engage each as his own level of development. This set of objectives was never fully explored in practice. The start which was made lost a good deal of its momentum after the reorganization of DHH.

What conditions exist in Denver which account for the escalation of demands for participation, providers' resistance to those demands and the resulting conflict? It might be argued that the sheer size of the neighborhood health program--its broad coverage locally, its large annual budget and the size of its staff and physical plant--make it an especially inviting target for demands for participation. A hard-learned lesson of the War on Poverty has been that if poor persons want control, it is important to have something tanbile to exert control over. The Denver neighborhood health program does represent hundreds of jobs and millions of dollars. On the other hand, residents of the Eastside appear to be demanding participation and

control at least as vociferously in other public services as well. The quality of housing has been a particularly hot subject recently. Members of the Eastside Action Council have taken a lead in demanding improved housing before Denver plays host to the 1976 Winter Olympics. Restricted opportunities for participation in other fields may, however, have contributed to heightened public interest in participation in the health program at earlier stages of its development.

The DHH has tended to shortchange technical assistance to health consumer representatives by confusing this role with others conceptually and in the pattern of task assignments to employees. The source, timing and commitment to the technical assistance delivered to consumer groups in equipping them to participate effectively has hurt the neighborhood health program and is, by contrast, a strong point of consumer involvement in Model Cities health planning to date. In leaving consumers to be self-taught, or, more bluntly, in contributing to their education through the school of hard knocks, the health providers in Denver have helped to cause some of their own more recent difficulties.

The success of Denver's health providers in getting a neighborhood health program started and successfully expanding it, making it a national showpiece, has meant that they paid less attention initially to training consumers for participation and involving them. Through their own talents and hard work they were able to accomplish on their own, tasks which consumers have

handled in programs in other cities. The Health Board's contributions are recognized by both providers and consumers in Denver, but to the Department of Health and Hospitals the program could have developed just as well without the Board.

DHH can argue with considerable justification that they are saddled with a shifting community. They have themselves to blame at least in part for making the shift so abrupt. The election mechanism and the failure of Denver Opportunity to hold the second Action Councils election anywhere near on time contributed to the abruptness with which the new community has been felt.

The leading actors were unable to contrive mutually satisfactory routes around the present impasse. When DHH administrators took actions which might have defused the situation, they neglected to give consumers the public role required to satisfy consumer' needs with regard to sustaining their own constituencies. This attitude derives from a basic refusal to view the program as thoroughly political in context. Thus, Cowen is quoted as agreeing that Frank Justice should be removed as Eastside Center Project Administrator, but arguing that he cannot take this action because the Health Board has demanded it. When Justice returned from a three-month leave of absence, his reassignment was delayed and made in a manner that made it difficult for the consumer representatives to define his removal from the Center as a victory for their side.

It was a victory which Cowen had made unnecessarily hard for them to translate into the hard currency of demonstrated leadership pointsto cash in with their neighborhood constituents.

Both consumers and providers have strong self-interests which are served by prolonging the current bitter confrontation. These ends are not consciously articulated or perhaps even felt by the participants, but are being served by the conflict and act to sustain it in subtle ways.

For providers, the prolonging of the conflict justifies their contention that the militant consumers are not really interested in health care, but are power-hungry scoundrels. On the consumers' side, the longer the conflict continues and the more bitter it becomes, the more forceful seems their argument that the administration of Health and Hospitals is hopelessly intransigent, racist and so forth. It must be conceded that the conflict does hold a real danger that it may eventually destroy the program, but all parties involved doubt this outcome, at least they did in the spring of 1970. They appear to assume that some sort of compromise will ultimately be found, which will be acceptable to both sides.

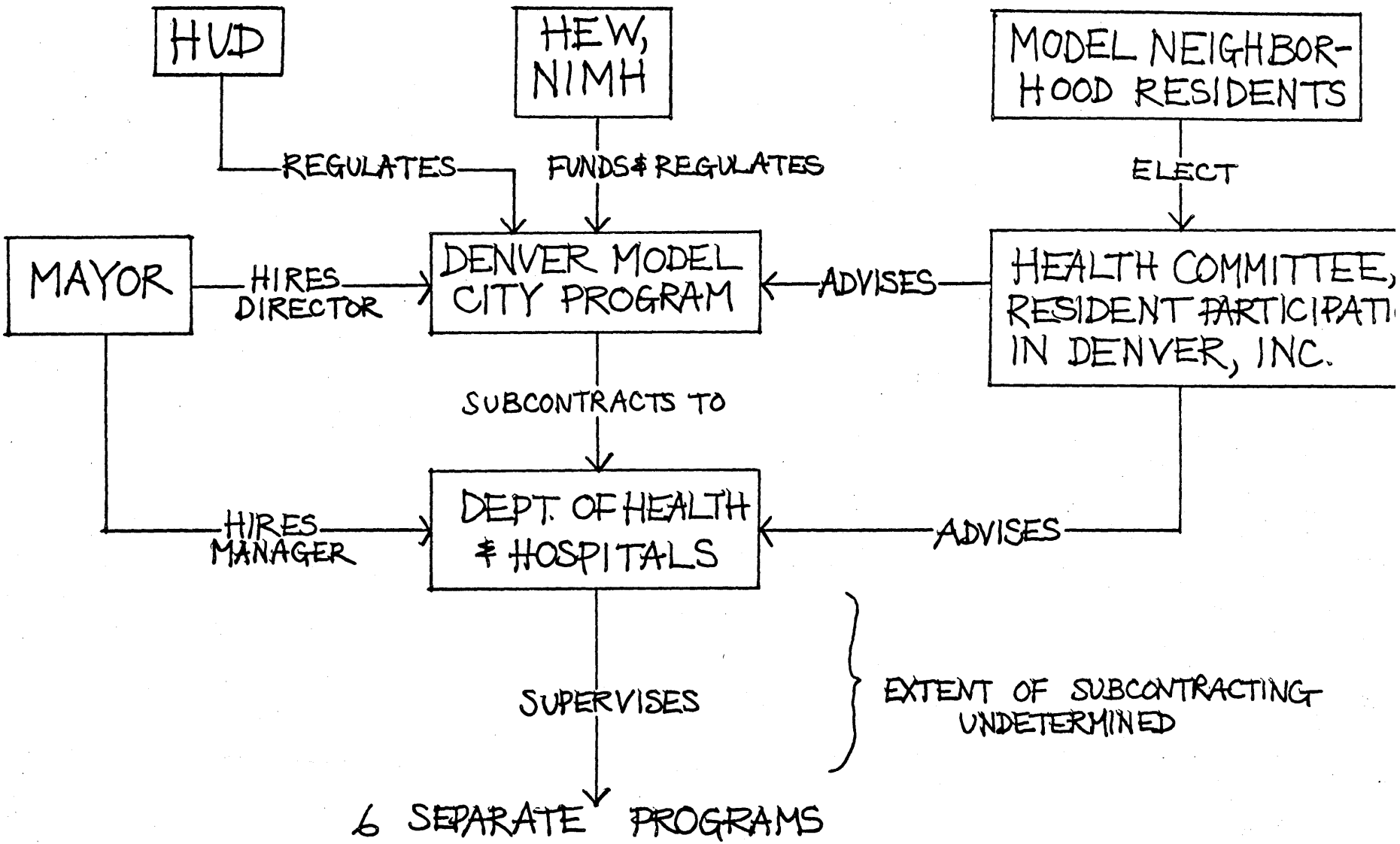
THE MODEL CITIES HEALTH COMMITTEE: A DIFFERENT APPROACH

Denver's former Mayor Thomas Currigan put his staff to work planning for Model Cities before the legislation was even passed. He traveled to Washington, D.C., to testify on behalf of the program. Denver's application was funded in March 1968 and committees of residents were organized at the start of the summer. The Health Committee, one of the last to be formed, was particularly active. With the help of a series of technical advisors, the Committee developed six mental health programs.

They focused on mental health because the neighborhood health program was already taken care of physical health. Since the comprehensive network of physical health services was in operation and in the process of expansion, further work in that area would have been useless duplication. DHH staff were involved to varying degrees in developing the program components, and the Department was named to be the delegate agency for the program, with a budget of $1.9 million for the current fiscal year.

Six program components--Alcoholism and Drug Abuse Center, Northwest Denver Mental Health Services, Psychiatric Halfway House, Mental Health Care for School Age Children, Center for Socially Alienated Youth, and Human Relations: Pride and Respect--were packaged together and funded with NIMH money earmarked for Model Cities.

FIG. VI-C: ORGANIZATIONAL RELATIONSHIPS, MODEL CITY MENTAL HEALTH PROGRAMS



Relations between DHH and the local Model Cities program are particularly interesting because they provide a more recent instance of the municipal health providers' contacts with resident groups, one which is fresher in the memories of the persons involved. The recent experience with consumer participation permits a useful comparison with the longer history of consumer involvement in the neighborhood health program. Some have charged that Health and Hospitals' behavior with regard to the Model Cities Program recapitulates their actions in the development of the neighborhood health centers and stations. If there is any truth to this observation,(and one does assume some consistency in the operation of large institutions) then the Model Citiesevents can shed some light on the earlier development of the neighborhood health program.

In a sense, comparison between the Model Citieshealth program and the neighborhood health program is unfair--the programs started at different times; their substance was different, as were the requirements confronting the sponsoring public agencies. Another key difference was that consumers were involved in the Model Cities program during the full year of planning which preceded implementation, whereas the first advisory board organized by DHH was brought in after most of the preliminary planning for that program had been completed. On the other hand, the situations are comparable enough in terms of the intended functions of consumer participation and the broad area of interest, health. Still another difference: while Health Committee members are paid $15 for each meeting they attend, Health Board members volunteer their time.

The quality of technical assistance made available to the Model Cities health group contrasts dramatically with that given the Health Boards of the neighborhood health program to date. The entire first year of the Model Cities program was devoted to training consumers and involving them in planning. The Health Committee had assigned to it technical advisors who were employed by a variety of different organizations. Some, but not all, of them were attached to DHH. The Health Committee was free to reject technical advisors they did not trust or like. They did so on several occasions.

The Model Cities Health Committee's first year of work stressed preparation for effective participation as well as accomplishing a significant amount of planning. The Model Cities staff refused to worry about formal mechanisms of representation until the Committee had developed into an effective group. Leighton Whitaker, Coordinator of Mental Health Planning for the Model City program, describes the emphasis of the first year effort:

> We cultivated a focus on evaluation. Evaluation started out as the least popular topic among residents, but is now very much at the fore. This evaluation orientation was carefully developed by explaining the process to residents in simple, eighth grade type language, which incidentally forced us to understand what we were talking about.[95]

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[95]Personal interview with Dr. Leighton Whitaker, Denver, April 14, 1970.

The Committee divided into small subcommittees which produced reports after conducting their own investigations of needs and existing programs in particular areas of mental health.

The Health Committee tested their technical advisors roughly and showed some the door. In Whitaker, they found an intensely committed individual who was able to stick with it and able to learn with them. He and others made available--much more explicitly than was true in the neighborhood health program--a series of educational offerings to prepare residents for effective involvement. The residents had specific and important tasks. Their assessments of neighborhood needs and the adequacy of existing service programs and institutions in a given area fed into decisions made about the mental health components. Although Whitaker was employed by DHH's division of psychiatry, he did not feel constrained to advocate their institutional interests. He identified closely with the residents on the Health Committee and consistently took their side in showdowns over assignement of priorities and the content of applications. Maxine Kurtz, Technical Director of the Denver Model Cities Program, labels the Health Committee "one of the two or three most successful of what I like to call 'establishment-residents alliances'."[96]

Whitaker credits the success of the Committee in large part to the tenacity of the then Chairman Melinda Saunders ... "She didn't cowtow to either side and she got everyone to work

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[96]Personal interview with Maxine Kurtz, Denver, April 9, 1970.

together and to work like hell," and to the Black Panthers, who came to meetings regularly, worked very hard and criticized proposals forcefully.[97]

When the DHH reorganization fight broke into the open, the Health Boards took a neutral position. The Model Cities Health Committee treated the dispute in a fashion consistent with their eagerness to do the hard investigative legwork of successful planning: They held a hearing on the issue, inviting both sides to present their cases for two hours. The Committee concluded that both parties were somwhat at fault. They felt that Health and Hospitals had engineered the takeover illegally because they had not conferred in advance with the funding agencies involved. They recommended that the two sides get together and make amends.

Maxine Kurtz, a key staff person from the beginning in development of the Denver Model Cities program, felt that Cowen did not really believe that the package of mental health programs would be funded. (It garnered a huge chunk of what NIMH had earmarked for Model Cities nationally.) Therefore, the Department was not fully prepared to start when the funds arrived. Whitaker found Health and Hospitals relatively uncooperative until the money was in the bag, at which point they became very interested.

Once DHH was signed on as delegate agency for mental health programs, latent disagreements between the Department and the Health Committee came to the surface. A prime example of the

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[97]Whitaker interview, April 14, 1970.

substantial disagreement that has developed between the two is their continuing argument over the appropriateness and potential effectiveness of an intergroup relations training program entitled "Human Relations: Pride and Respect." "Pride and Respect" will use a variety of teaching techniques to make public agency personnel aware of their insensitive and discriminatory attitudes and behavior and will attempt to change these so that they can give services to the poor and minority group members more effectively. The program was designed by the Health Committee in conjunction with a multi-racial, interdisciplinary group, Consultants in Human Relations, Inc , which has done a good deal of human relations training locally.

The style and substance of this conflict form a classic instance of provider-consumer opposition. The providers stick to their own definitions of residents' needs, perceive the program as an intrusion into their areas of professional expertise, and seek to redirect the consumers' proposal. The consumer group feels that their careful work is being cast aside and that the providers are trying to scrap the guts of the proposed component.

Cowen characterizes "Pride and Respect" as an "extremely nebulous program."[98] He claims that NIMH requires that programs it funds have a direct impact on community mental health, a criterion which he feels "Pride and Respect" would have a tough

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[98]Cowen interview, April 8, 1970.

time meeting. "Pride and Respect" is one of the program components which members of the Health Committee care about most. The ideas underlying its development really did emerge directly from their own concerns, so they defend the program vigorously. On the other hand, Dr. Stuart W. Hollingsworth, medical director for the mental health components, charges that "some cagey professionals from the private sector have lobbied the Committee" into accepting programs which these "wheelerdealers" are advocating for purposes of personal gain.[99] Dr. Whitaker, now head of the community mental health program at the University of Colorado Medical School, dismisses this view, pointing out that the highly qualified members of Consultants for Human Resources, Inc., who helped to develop the program and are intended to run it, did not want to take on the project until the Health Committee persuaded them to do so. If it is implemented under the direction of the Consultants for Human Resources, several of the principals in it would have to take substantial salary cuts from what they are currently earning. The group only incorporated at the behest of Whitaker.

Whitaker relates that another desire of the residents that is unpopular in the eyes of health professionals was their decision to give highest priority to drug addiction and alcoholism programs. He cites as reasons for this lack of professional enthusiasm: professionals' dislike for working with addicts and alcoholics, their feeling that existing programs do not seem to work, and addicts

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[99]Personal interview with Dr. Stuart Hollingsworth, Denver, April 9, 1970.

and alcoholics' relative immunity to the traditional tools of the psychiatrist. Members of the Health Committee surveyed needs in this area as they did in all areas of mental health. They determined that the demand for services was great and that it represented a field of tremendous neglect and previous lack of success locally. Committee members had special access to things happening in the community which enabled them to say accurately, for example, what the real obstacles to utilization of existing treatment facilities are and to describe fully the reservations potential patients would have about alternative program approaches.[100]

Another conflict between the Committee and DHH arose when Douglass Carter was hired by DHH as Administrative Officer in charge of the Mental Health Program. The Health Committee did not have a say in the selection of Carter, a black man with considerable experience in a local manpower training program.

Cowen feels that the mechanism for communication between the Health Committee and DHH is "lousy" because they sit totally separate from DHH, they report to Resident Participation in Denver, Inc., which communicates with the City Development Agency, which talks to DHH.[101] The line of communication is too indirect and there is no formal relationship between his Department and the

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[100]Whitaker interview, April 14, 1970.

[101]Cowen interview, April 8, 1970.

groups who will implement specific program components. Cowen comments that

> The experience of Health and Hospitals in developing health boards didn't feed into Model Cities development. They didn't ask for help. A lot of people here went around stating that a great many things would be available and possible under Model Cities. They had no real exposure to real neighborhood people, didn't know it wasn't in the realm of capability of this group of people.[102]

He does recognize the existence of a strong resident contribution to the Mental Health Program,"in terms of how problems were verbalized, where accents were placed."[103] His evaluation of the Center for Socially Alienated Youth component is that it was based on "a verbalization of community concern, not based on any particular knowledge."[104]

Hollingsworth makes the interesting observation about consumer participation in the program:

> There is a lack of aggression of specific, but lots of conflict on the global issues. It's a sort of ritual. They don't really do anything. For example, they were supposed to be responsible for training. I went over there and they hadn't done anything along those lines.[105]

Whitaker questions DHH's commitment to consumer participation:

> Health and Hospitals is ostensibly pro participation, but they continually point to things they have fought against and accepted against their will as evidence of their support for the concept.[106]

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[102]Cowen interview, April 8, 1970.

[103]Ibid.

[104]Ibid.

[105]Hollingsworth interview, April 9, 1970.

[106]Whitaker interview, April 14, 1970.

He regrets that the Committee did not write more stringent provisions for consumer participation into the work programs to be used in guiding implementation of the mental health components.

A peculiarity of the resident participation structure of the Model Cities Program is that residents were elected in the spring of 1970 to sit on specific committees. Each committee selects a member to sit on the executive committee. This framework is likely to cause problems because the distribution of funded programs among committees is very uneven. Some have several, others none, leaving a few overloaded and the others without any real function.

DENVER -- CHRONOLOGY OF MAJOR EVENTS

	Neighborhood Health Program:
Dec. 1964	Denver War on Poverty approves Dept. of Health and Hospitals' proposal for a neighborhood health center, application to be submitted to OEO
Aug. 1965	OEO approves funds for Eastside Neighborhood Health Center
early 1966	Lay Advisory Board organized as vehicle for consumer participation in planning and running the new health center
Mar. 1966	Eastside Neighborhood Health Center opens for business
June 1966	DHH seeks approval of its Board and that of the Denver War on Poverty for an application for a second neighborhood health center; DHH Board rejects the proposal, then reverse itself the following month; local Medical Society and other established medical organizations express their opposition to a second center
July 1966	First neighborhood health station opens
Dec. 1966	Denver Opportunity, Inc. (formerly Denver War on Poverty) first tables, then approves DHH application for a second health center
Aug. 1967	First election for Neighborhood Action Councils is held
Dec. 1967	Denver Opportunity Board of Directors approves the Health Board Structure, a document specifying Health Board powers and responsibilities
April 1968	Westside Neighborhood Health Center opens for business
Aug.1968	Denver Dept. of Health and Hospitals administrators announce reorganization scheme, placing direction of the neighborhood health program in the Manager's office; staff in the division formerly responsible for the program express vigorous opposition

Sept. 1968	Staff opposition to reorganization scheme intensifies, Drs. Warner and Johnson suspended for their opposition
Sept. 11, 1968	Johnson and Warner protest their suspensions, begin court fight against reorganization; Model City Health Committee holds a hearing on the controversy--both sides testify
Sept. 12, 1968	District judge issues temporary restraining order halting the reorganization and the suspensions of Johnson and Warner
Sept. 25, 1968	DHH administrators and Johnson and Warner agree to settle their differences out of court, and reorganization goes forward. The two men return to their modified jobs.
April 15, 16 and May 1, 6, 1969	Career Service Board holds hearing on Frank Woertman's appeal of dismissal; the Board grants his appeal on May 20, 1969'
June 29, 1969	Bomb blast wrecks part of Eastside Center
Oct. 1969	Denver Opportunity Neighborhood Action Council elections held, new Eastside NAC meets and elects Frank Bailey, Bailey appoints a new Eastside Health Board
Oct. 31, 1969	The militant new Eastside Health Board holds an early first meeting (prior to the time provided for in the Health Board Structure), the Board details criticisms of the Eastside Center and demands resignation of the Administrator and his assistant
Nov. 1969-April 1970	Eastside Health Board and DHH deadlocked about demands for change of administration at the Eastside Center and new powers for the Board; Administrator of Center granted leave of absence
May 14, 1970	Denver Opportunity Board of Directors votes to withhold authorization of a new contract with DHH for operating the neighborhood health program (old contract expired Dec. 31, 1969); OEO refuses to intervene, calls the dispute a local matter for local resolution

Model Cities health programs:

early 1966	Mayor Currigan testifies in favor of Model Cities legislation before Congress in Washington, D.C.
mid-1966	Mayor appoints interagency committee to draft Denver Model Cities application; Dr. Cowen, Manager of DHH, responsible for health section
Aug. 1967	Currigan appoints his special assistant as his representative for the program and names Maxine Kurtz staff director; they convene Interagency Task Force to begin planning although formal approval for application not yet announced
fall 1967	City contracts with Core City Ministry to organize citizen participation in the program
Nov. 15, 1967	HUD notifies Denver of its selection as a Model City
summer 1968	Health Committee organized
mid-July 1968	Retreat held for members of all residents' committees; Health Committee returns to work surveying existing mental health programs, defining needs and proposing solutions
early Sept. 1968	Health Committee submits draft paper on needs and proposal
Sept. 7, 1968	Second retreat for committee members
Sept. 18-21, 1968	Federal Work Team convenes in Denver, meets with each of the planning committees to review residents' draft papers
Oct.-Dec. 1968	City Council reviews program proposals
Jan. 6, 1969	City Council approves submission of Model City planning documents
Jan. 1969	First-year implementation of Model Cities program begins, although HUD approval of specific programs not yet received
first half of 1969	Health Committee works to refine their proposals, local and regional staff channel proposals into a six-component package for submission to NIMH in October

Nov. 1, 1969	NIMH funds Model Cities mental health programs
mid-Nov. 1969	DHH begins to hire staff to carry out mental health programs
April 1970	First elections to committees of Resident Participation in Denver, Inc.; results in substantial change in membership of the Health Committee

CHAPTER VII - THE YEATMAN HEALTH CENTER, ST. LOUIS

INTRODUCTION

THE HEALTH CENTER

The Yeatman Health Center contrasts sharply with the Denver Neighborhood Health Program in its organizational structure, in the nature of the local setting and the development of its approach to consumer participation.

In brief, the Yeatman Health Center is a neighborhood health unit sponsored by the Department of Health, Education and Welfare under Section 314(e) of the Partnership for Health Act, P.L.89-749. It is consumer-controlled in the sense that funds go directly to the Yeatman District Community Corporation (YDCC) which is the "parent corporation" from which the Health Center developed. The YDCC is run by a 60-member board elected by residents of the Yeatman area. A Committee of YDCC Board members and interested residents has immediate control over the Center. The Director of the Center reports directly to it.

The stated objectives of the Center emphasize: (1) community control, (2) provision of preventive and curative health services, (3) conduct of health education programs, (4) training of para-

professionals, and (5) planning for group prepayment for care.[1]

The Center was initially funded in June 1968. It was planned at first that services would be delivered on an interim basis from a City Health Department clinic in the neighborhood. This idea was eventually abandoned and the Center finally opened its doors to the public in July 1969 in a renovated warehouse of about 10,000 square feet.

The Center offers a comprehensive set of health services to ambulatory patients: general medicine, obstetrics and gynecology, pediatrics, and dentistry. Other specialties available on the premises include: internal medicine, minor surgery, opthalmology, radiology and psychiatry. In addition, referrals are made to specialists at the St. Louis University School of Medicine and the University Hospitals. The Center maintains its own pharmacy, diagnostic X-ray equipment and laboratory. It includes units in social service, public nursing, nutrition and health education. A pair of station wagons provides transportation to and from the Center for those who need it. The Center is a distribution station for a supplemental food program, which attracts mothers with young children and gives the Center a chance to examine them and to provide health instruction.

The Center opened using a team approach to rendering care, but has deviated from that principle somewhat because it led to an

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[1]Yeatman Health Center, "Progress Report, Yeatman Medical Health Center," January 1970, p. 1.

extremely uneven work load -- some physicians were overworked and some specialists had time on their hands. In addition, there were substantial delays for patients waiting to see doctors.

In May 1970, the Center staff were seeing about 150 patients each day. During the first 8 months of operation, the Center has seen approximately 9,000 patients who have made a total of 21,000 visits. All residents of the Yeatman District are eligible for services of the Center and they are charged according to their ability to pay.

THE COMMUNITY SETTING

The Yeatman District is not a natural community. Its boundaries were set by the Human Development Corporation (HDC), the local Community Action Agency, when it determined the shape of its 14 neighborhood target areas. Yeatman is the largest of these, covering approximately 7 square miles. The District lies one mile west of the City's downtown business district. Its western boundary is two blocks away from Homer G. Phillips Hospital, the municipal hospital which was segregated for blacks until officially desegregated after World War II and still a predominantly black hospital. The notorious Pruitt-Igoe housing project is directly east of the district. The district is liberally dotted with churches, a fact which reflects a heavy religious affiliation and interest in the area. St. Louis University is located immediately to the South of the district. The District's total population of 62,000-70,000 is approximately one-third of the total official poverty population of the city as carved up by the HDC.

The profile of social and physical characteristics is a classical portrait of an urban U.S. ghetto. The population is over 90% black. Average family income is about $4,500. 55% of the population lives in households with incomes under $3,000. The unemployment rate is almost 13%. Females outnumber males by a ratio of 55:45. 15% of the approximately 16,000 families are on welfare. Average level of educational attainment in 7th grade and half of students today fail to complete high school. The median age is 34.

HEALTH CONDITIONS

Among the most common health difficulties in Yeatman before the establishment of the Health Center (and afterwards as well) were venereal disease, anemia, infant diseases, high blood pressure and heart disorders. The health of neighborhood residents was much poorer than the national median as is indicated by the following comparison:

TABLE VII-A: SELECTED DEATH RATES IN YEATMAN COMPARED TO THE NATIONAL MEDIAN[a]

	Yeatman	National Median Rate
Resident death rate per 1,000	15.0	11.0
Infant death rate per 1,000 live births	40.0	25.6
Accident death rate per 100,000 population	65.5	51.1

[a]Organization for Social and Technical Innovation, "Draft Health Component: Yeatman District, St. Louis," Cambridge, Mass., February 1968, p. 4.

HEALTH SERVICES AND FACILITIES

Prior to the establishment of the Health Center, residents obtained health care from the city Health Department's maternal and infant care facility, from a well-baby clinic located at the eastern edge of the District, at city hospitals and from the half dozen physicians (plus one dentist) maintaining private practices in the area. Primary limitations of the existing services and facilities were poor accessibility to Yeatman residents, overcrowding of facilities, the expensiveness of alternative sources of care.

The City Health Department operated the Jefferson-Cass Clinic, a maternal and infant care facility located across the street from the Pruitt-Igoe housing project. In addition to the M & I services, the Clinic had a TB detection unit and a limited child guidance service. The Human Development Corporation's Headstart program offered preventive health examinations to participating children.

Most adult ambulatory services were obtained at the Homer G. Phillips Hospital outpatient clinic and emergency room. Patients waited hours at the clinic and the emergency room was congested with clinic overflow. In order to obtain free service at either of the municipal hospitals, residents needed certification from the Welfare Department. Getting certified was a long, complicated process and carried a one-year residency requirement. Some residents traveled to City Hospital Number One located six miles Southeast of the Yeatman District. Ambulance services were available through the municipal hospitals, but they were often swamped, and from expensive private firms.

No mental health out-patient services existed for adults. In the area of mental health for children, there was the small Jefferson-Cass Child Guidance Program and the child guidance services of the Children's Services Center just outside the target neighborhood, which was open only to families referred to it by the Welfare Department. Adults had to travel to Malcolm Bliss State Hospital or to the Arsenal St. State Hospital, both five miles from the target area. Recently, a community Mental Health Program has been instituted by Malcolm Bliss. Some residents receive care from one of its decentralized facilities.

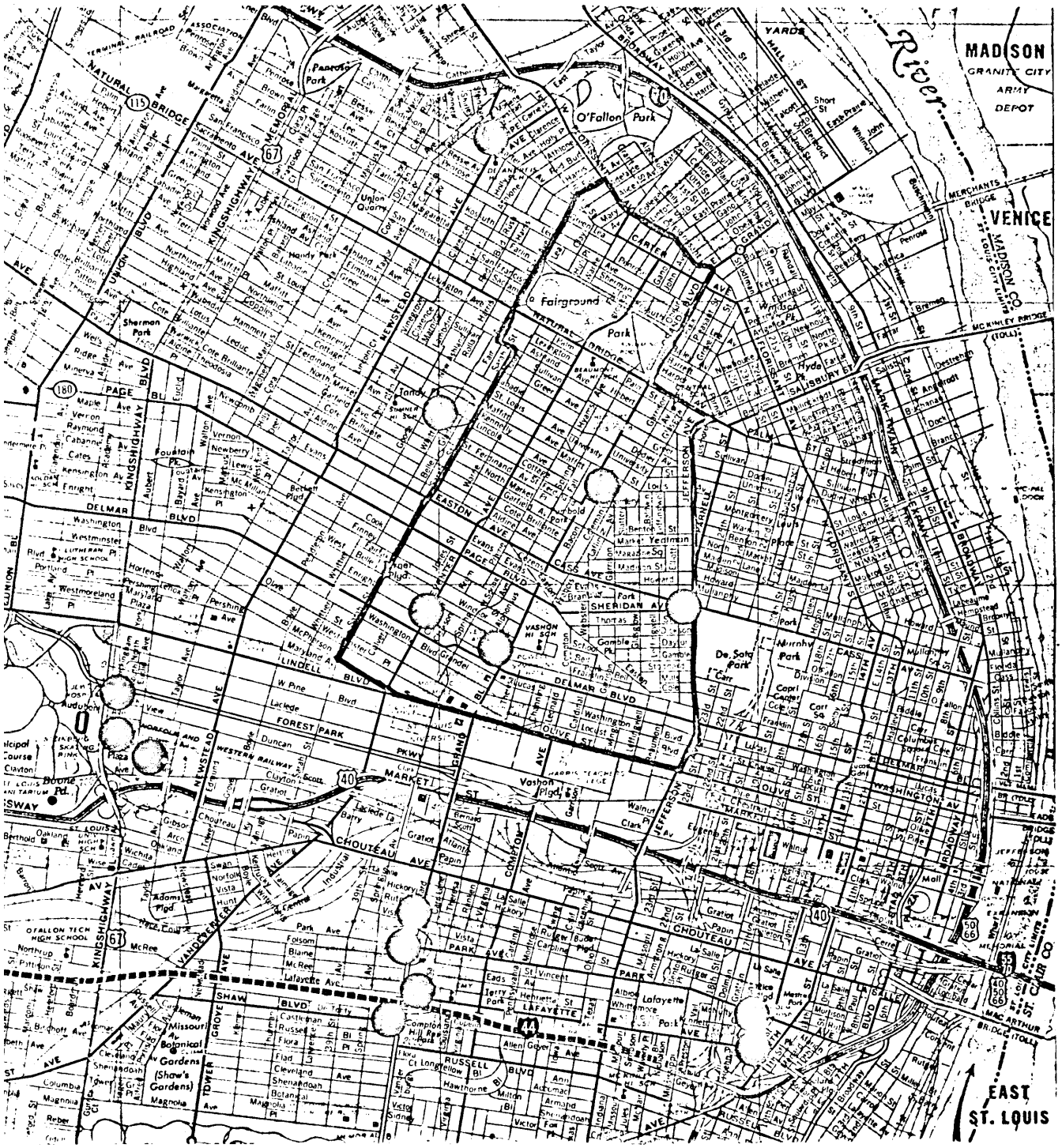
The nearest services for alcoholics were provided at the St. Mary's Infirmary detoxification center upon referral by the Police Department, Part of the Yeatman District was included in this program.

DEVELOPMENT OF THE HEALTH CENTER

ORGANIZATIONAL ANTECEDENTS

The Yeatman Health Center developed as a "component Program" of the Yeatman District Community Corporation (YDCC) which was incorporated in 1969 under the sponsorship of the Neighborhood Service Project (NSP) to provide comprehensive social services to residents of the area. Although highly interesting, the power plays and political struggles which marked the early stages of the development of the Yeatman Health Center's parent corporation are only marginally relevant to the development of the Center itself. It is

FIG. VII-A: HEALTH FACILITIES IN AND AROUND THE YEATMAN DISTRICT



1. Yeatman Health Center
2. Jefferson-Cass Clinic
3. V.A. Hospital
4. Children's Services Center
5. Christian Hospital
6. Homer G. Phillips Hospital
7. Jewish Hosp.
8. Barnes Hosp.
9. Washington Univ. Med. School
10. Fermin Desloge Hospital
11. Cardinal Glennon Hosp.
12. Incarnate Word Hosp.
13. Missouri Pacific Hosp.
14. Malcolm Bliss Hosp.
15. City Hospital #1

critically important, however, to trace the evolution of consumer participation and the development of community control in the NSP as a whole because this set of experiences is the genesis of issues of consumer involvement specific to the neighborhood health center. According to the consultants who assisted St. Louis' participation in the NSP,

> The origins of the NSP in St. Louis ... are shrouded in tangled relationships among existing neighborhood groups, the Community Action Agency ..., the Model Cities agency, and the mayor's office. The political situation in St. Louis was already marked by battles over the anti-poverty pie; when another piece was dangled in the form of a very lucrative NSP program, the battle lines were drawn anew.[2]

The National Service Project was originated in 1966 to sponsor multiservice centers in disadvantaged neighborhoods across the country. The Project was administered by a group of federal agencies operating together as the Washington Inter-agency Review Committee (WIRC). The Department of Housing and Urban Development was convenor of the Committee, which consisted also of the Department of Health, Education and Welfare; the Office of Economic Opportunity; the Department of Labor; and the Bureau of the Budget. The initial vision of placing a multiservice center in every poor neighborhood in the country was revised in short order to establishing pilot projects in 14 cities. 7 -- later reduced to 5 -- of these were designated to be community corporation cities. St. Louis was one

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[2]Organization for Social and Technical Innovation, "St. Louis Corporation History," report to OEO, June 30, 1969, p. 2.

of these. More immediate supervision of the local projects was handled by Federal Review Teams composed of the regional representatives of the same participating departments, also headed by HUD.

The local community action agency was the presumptive sponsor of the NSP, so the Human Development Corporation ran the program in St. Louis. The WIRC prescribed that the local programs mesh with the ideal of, and any local plans for, comprehensive service delivery systems.

In late 1967 the Yeatman District was selected as the focus of St. Louis's participation in the new federal National Service Project. The ultimate vehicle for St. Louis' participation in the NSP was provided when the Yeatman District Community Corporation (YDCC) was formed. The Yeatman Health Center is an offshoot of that body.

The YDCC staff and its initial programs were by and large extensions of the Yeatman Center, a neighborhood station of the St. Louis Community Action Agency, which contracted with the local Urban League to operate the facility from 1965 to 1967. The Yeatman Center was operated directly by the Human Development Corporation from 1967 to 1969 after the Urban League was removed from the job. Thus, at the time that St. Louis' participation as an NSP city was announced, Yeatman was enjoying the services of a neighborhood center run by the Urban League under contract to the Human Development Corporation. Jeff-Vander-Lou, a community corporation which was the strongest grass roots organization in the district at the time, militated for removal of the Urban League from

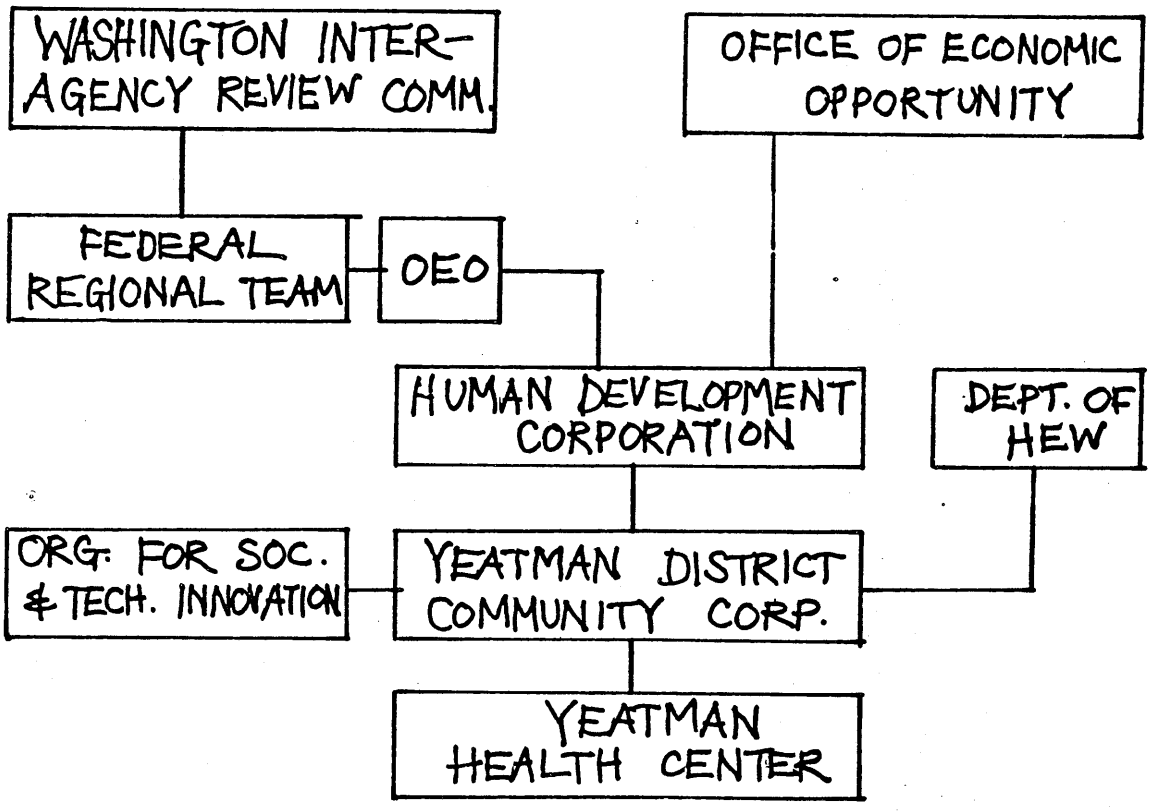
Yeatman. Since the beginning of the year, some members of Jeff-Vander-Lou had been functioning informally as the Neighborhood Advisory Council (NAC) for the Yeatman Center, operated by the Urban League. A variety of neighborhood groups were involved in the early stages of planning for the new program. A strong conflict developed between members of Jeff-Vander-Lou and supporters of the Yeatman Center over who would control the NSP. An election was held to choose an Interim Board for the neighborhood organization charged with administering the program locally. Jeff-Vander-Lou members emerged from this contest with a distinct minority of seats on the Board, which decided to constitute itself as the Yeatman District Community Corporation. Jeff-Vander-Lou members gradually withdrew from active involvement with the new Corporation. Conflicts between the two neighborhood corporations have persisted, focusing on different competitions for public funds and responsibilities. The struggle has been resolved to some extent by a differentiation of their respective programmatic roles -- Jeff-Vander-Lou concentrating on housing rehabilitation projects and the YDCC handling other types of programs, mostly in the area of social welfare.

The split between the two groups is pertinent to questions about the later development of community control over the Health Center. The lesser involvement of Jeff-Vander-Lou members, which resulted from the split, has meant that fewer of the younger men active in Jeff-Vander-Lou are involved with the health program. The group which originally captured control of the YDCC -- by

definition a much more inclusive organization geographically than Jeff-Vander-Lou -- has, of course, deeply influenced its subsequent development. One consequence of its dominance has been to narrow the range of types of local residents who might otherwise have been a part of the group of citizens responsible for planning and implementing the neighborhood health center.

In oversimplified graphic form, the administrative relationships of the YDCC at that time can be diagrammed as follows:

FIG. VII-B: ORGANIZATIONAL RELATIONSHIPS, YEATMAN HEALTH CENTER[b]



[b]This diagram is a modified version of one presented in Abt Associates, "A Study of the Neighborhood Center Pilot Program, Vol. 2: An Evaluation of the Thirteen Neighborhood Service Programs," September 1, 1969, p. 801.

ORGANIZATIONAL FRAMEWORK

The form of community control which evolved through the establishment of the Yeatman District Community Corporation determined, in large part, the eventual structure of consumer control of the Yeatman Health Center.

Active control of the Corporation rests with the Board of Directors. Its 60 members must be General Members of the Corporation and 21 years old. 51% of the members must meet the indigency requirements of OEO. Directors are elected for staggered 3-year terms -- one-third of the members come up for election each year. Implementation of this provision has been delayed, so that the 1970 election was the first time that only one-third of the Board was up for election. At the prior election, the Directors drew lots to determine who would have terms of one, two and three years. The Board meets as a whole at least once a month. In addition, it maintains seven basic committees which are each chaired by a Board member. The Committees are: Health, Education, Employment, Physical Development, Social Welfare, Recreation/Youth, and Economic Development. The Committee membership consists of seven Board members plus all interested residents of the area. The Health Committee since its inception has been chaired by Mrs. Arabella Lawrence, an elderly black woman and member of the Board who commands immense respect in the neighborhood. The Committee has included approximately thirty persons, including the half dozen YDCC Board members in addition to Mrs. Lawrence.

The Health Committee was complemented by four more local health committees attached to each of the four sub-stations of the YDCC which were established before the Health Center came into existence.

At the time of its incorporation the Yeatman District Community Corporation restricted membership to residents who were at least 21 years old and persons doing business or other work involvement in the District. In July 1969, the minimum age was lowered to 18. The Board is considering lowering the age further, perhaps to 16. Residency in the District for 90 days is required for membership. Corporation employees can be members, but are not eligible for election to the Board of Directors. A special category of Affiliate Members exists to accommodate persons otherwise ineligible for General Membership, but wishing to be involved in the affairs of the Corporation. They may serve on the Advisory Committee and vote there, but cannot vote on general Corporation business and cannot hold office. They are "permitted from time to time to participate in and assist with the general functions of the Corporation."[3] Amendments to the original set of by-laws have been concerned almost entirely with eligibility for membership, filling vacancies on the Board of Directors. In addition, adjustments were made in determining composition of the Membership Assembly and setting of quorums.

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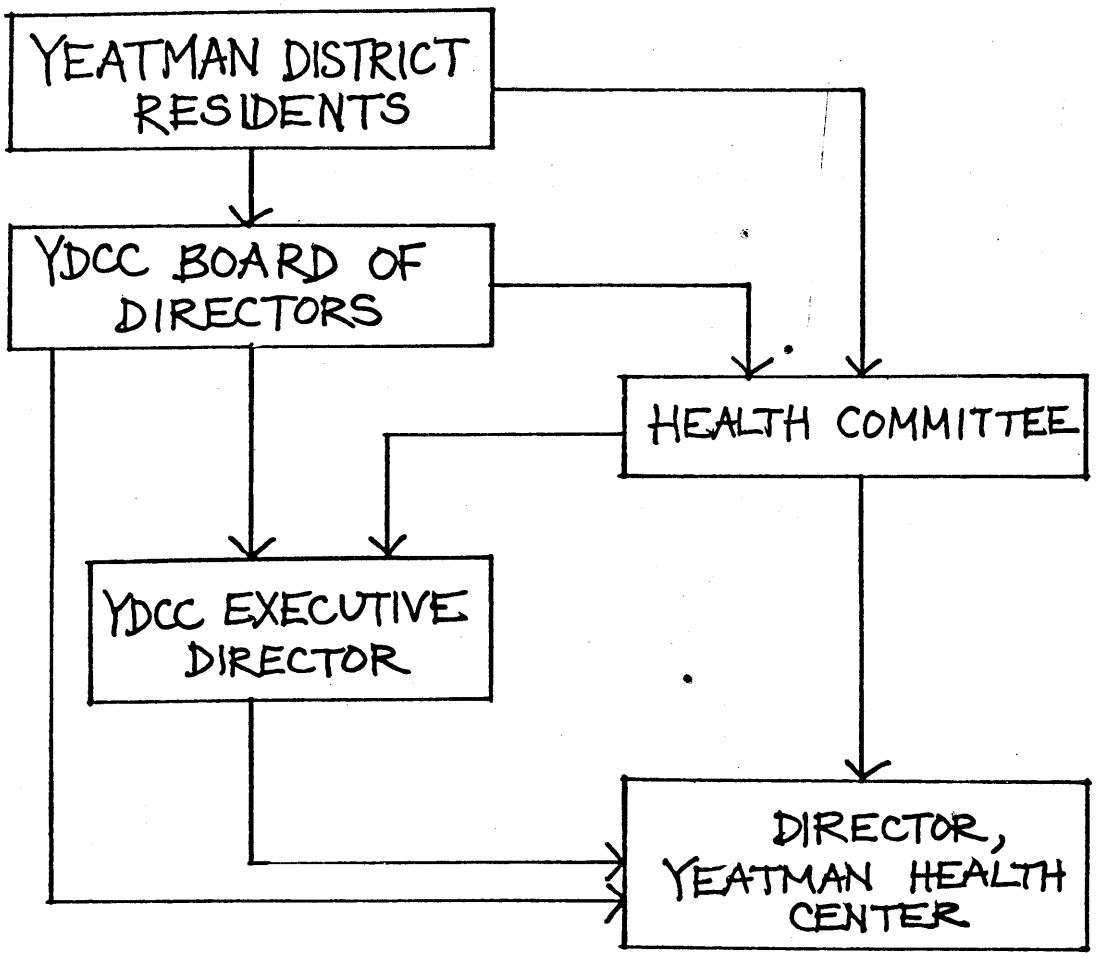
[3]Yeatman District Community Corporation, "Amended By-Laws," St. Louis, August 27, 1969, p. 1.

The following chart presents the YDCC's organizational relationship to the Health Center in its barest essentials:

FIG. VII-C: LINES OF AUTHORITY WITHIN THE YEATMAN DISTRICT WITH REGARD TO THE HEALTH CENTER



In terms of formal structure, the Director of the Health Center is responsible to the YDCC Board through the YDCC Executive Director. In actual practice, the relationship between the Health Center Director and the YDCC Executive Director is more collegial than supervisory or hierarchical. The Director of the Health Center tends to deal directly with the Board and takes his immediate cues from the Health Committee.

PLANNING FOR THE HEALTH CENTER

A loosely knit group of representatives from various local agencies worked together to produce the first documents required by the Neighborhood Service Program in 1967. Specific planning for health services began only after the city had received additional planning funds in response to its NSP I application.

The Organization for Social and Technical Innovation (OSTI) was hired by OEO to provide technical assistance to the neighborhood corporation NSP cities. OSTI's responsibilities in St. Louis included helping to set up the neighborhood corporation, assisting in the organization of an interim Board, initiating planning activities with residents' committees, and defining interorganizational relationships. OSTI staff were instrumental in guiding the early work of the YDCC Health Committee. The first health planning done under the NSP occurred, however, before the Health Committee was actually established and functioning regularly.

Members of the Interim Board of the YDCC, HDC staff and OSTI

personnel collaborated during October 1967 to produce the NSP II. The development of the health clinic proposal occurred against a backdrop of intensive political activity swirling around issues of corporation by-laws and powers, Board members' attempts to land jobs for themselves and their families, and disputes with other neighborhood groups and with city agencies.[4] The initial health component was developed largely by professionals assisting with preparation of the NSP II.

The unveiling of the NSP II brought forth a deluge of criticism directed at the section on health. Health agency officials attacked the proposal to establish a neighborhood clinic, arguing that the proposal was based upon inadequate data about neighborhood needs and failed to relate smoothly to services and facilities which were already in existence.[5]

Health care was not a top priority concern of area residents. Residents' primary interests were in the crucial areas of employment, housing and education. Several proposals for substantial programs in each of these areas were eventually submitted to the federal government by the Corporation, but for a variety of reasons failed to attract any large-scale funding. Employment moneys were all funnelled into the city's Concentrated Employment Program. Jeff-Vander-Lou had somewhat of a corner on housing programs by virtue of its handling the Model Cities housing component. The YDCC

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[4]Organization for Social and Technical Innovation, op. cit., pp. 27-28.

[5]Ibid., p. 27.

did receive funds to do some social planning for Model Cities. The PHS grant for a comprehensive health center made the Center very much the most significant and visible of the component programs. When funds were granted for the second year of operation, the Center constituted about 75% of the total YDCC budget.

The NSP II proposal section on health consisted of a three-phased action plan: (1) development of a comprehensive group practice for the neighborhood, (2) immediate provision of direct treatment services during the period when the group practice was being planned and established, and (3) the training and development of community health workers. The NSP II application estimated that about 20,000 of the approximately 65,000 residents of the District would use the Center, which was to be open to all of them.

The proposal was accompanied by letters of endorsement from the heads of the Department of Health and Hospitals, the Health Commissioners, the State Division of Mental Disease, the Model City Agency. The Model City Agency director noted that "the quality of citizen involvement in the development of the Yeatman Health Care Plan, is consistent with the St. Louis Model City planning approach."[6]

OSTI's health consultant Dr. Robert Buxbaum entered St. Louis with a strong conviction in favor of community control. He argued that health care

> should be community-based, and should be controlled and paid for through community administration of funds. Entry into the community by professionals

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[6]A. Donald Bourgeois, letter of endorsement accompanying St. Louis NSP II.

> should be regulated by the community, and a contractual format used to determine the range and quality of services.[7]

Buxbaum's position was based on an analysis of the prevailing health care system which holds that current approaches are sustained by scientific, professional constituencies and bureaucracies:

> ...when the funding is given for a categorical program for the poor, it generates its own administrative and bureaucratic structure to control the disbursing of services.... Once established, and once entombed in the civil service structure, the service will persist, often past its period of usefulness.[8]

> ...any appeal for more funds to insure a "better delivery of services" will of necessity arise from within the professional group in the structure. It is no accident that many programs are "control programs -- VD control, alcohol control, and so forth; what is really controlled are the people, and the people are almost invariably poor and administratively helpless.[9]

Buxbaum's approach, given this perspective, was to engage in health "advocacy," akin to the advocacy planning movement in the field of urban planning.[10] Given the posture and structure of self-interests of professional constituencies, he insisted that "The only way to

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[7]Robert C. Buxbaum, "Health Advocacy Planning: A Position Paper," a paper prepared for the Organization for Social and Technical Innovation, Cambridge, Mass., February 17, 1968, pp. 7-8.

[8]Ibid., p. 3.

[9]Ibid., p. 5.

[10]See Paul Davidoff, "Advocacy and Pluralism in Planning," Journal of the American Institute of Planners, Vol. 31, No. 4 (Nov. 1965), pp. 331-338; and
Lisa R. Peattie, "Reflections on Advocacy Planning," Journal of the American Institute of Planning, Vol. 34, No. 2 (March 1968), pp. 80-87.

reform the system is through action by community groups -- the users."[11] Thus the first step in the style of advocacy which he espoused was community organization.

Buxbaum met with the Health Committee for the first time in early December. His initial assessment of the Committee was that it was "unsophisticated and unfamiliar with the health situation, the city operation, the clinics, attitudes, and complicated questions of financing and organization."[12] Under his guidance, the group grew rapidly to overcome these problems. Both Buxbaum and the current administration of the Center characterize the regional HEW office in Kansas City as consistently cooperative and highly competent. Buxbaum assembled an extraordinarily capable group of professionals to help him in this task. He recruited Dr. Fred Sargent, a local physician, to serve as medical advocate for the group. He felt that there needed to be a physician working with the group who was living in St. Louis, because he could not be there all of the time. Dr. Kay Keiser of OSTI was brought in to help with financial aspects of the planning and with general problems of programming and management.

Committee members and Center staff who knew them are full of praise for the job done by Buxbaum and Sargent in getting the program

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[11] Robert C. Buxbaum, "A Draft Manual for Community Health Committees," a paper prepared for the Organization for Social and Technical Innovation, Cambridge, Mass., February 17, 1968, pp. 1-2.

[12] Organization for Social and Technical Innovation, op. cit., p. 31.

successfully underway through their careful handling of relations with local agencies and associations, and sensitive nurturing of the Health Committee itself. Sargent was responsible for contacting established medical institutions. Although he was not at that time a member of the local Medical Society, he approached the President who was a personal friend and got invited to present the proposal to the Society's governing council. When he asked them for a resolution supporting the Yeatman proposal, they responded by offering to table the matter or to pass a resolution reiterating their support for community medicine in general terms. "The latter would've been just words, so I said to forget it,"[13] Sargent recalls. The Society assigned a man from their staff to attend Health Committee meetings. He did come regularly, but upset Committee members with his stiffly professional manner.

Dr. Sargent cites the enthusiasm and spirit of the Health Committee with being a major force for convincing actors whose support was required:

> The thing that impressed me the first time I went to a Yeatman Corporation meeting was the tremendous enthusiasm and interest of the group. I was caught up in this feeling. It was the same with the Health Committee meetings.... If we could get people to meetings, they would be caught up in the enthusiasm. The meetings sold people, showed them by putting them in the middle of what was going on.[14]

Sargent maintained a careful sense of pace for the Committee's development into an effective decision-making body. At first they

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[13]Personal interview with Dr. Fred Sargent, St. Louis, May 6, 1970.

[14]*Ibid.*

expected him to take charge, but he refused to do so.

> If I hadn't been terribly persistent in not wanting to take over, nothing would've happened.... They needed my medical knowledge and access to established medical organizations. But so many decisions on this kind of thing are not at all medical. Unless people are given the responsibility, they won't feel it's theirs.[15]

Roger Steffen of the YDCC staff was assigned to the Health Committee and helped accomplish a wide variety of administrative tasks, including coping with applications and other forms. Sargent recalls, "Steffen kept repeating that you can't let someone else take it over.... He convinced us that it's better not to have a small program which someone is offering you unless the sponsors will go half way and do things as the Health Committee wanted."[16]

Dorothy Stauffer, Director of the Department of Social Work for the local Department of Health and Hospitals, advised on questions of health education and social services. In addition, she was an invaluable source of information on the arcane politics of the established health agencies and institutions in the city. At several points she suggested ways of proceeding based on this knowledge, suggestions very helpful to those less familiar with the local situation.

James Howard, a black man on the staff of the Health and Welfare Council, was a key person throughout the planning period. Howard strongly urged the Health Committee to try to establish a

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[15] Ibid.

[16] Ibid.

comprehensive health program, not just another partial service. He helped the Health Committee to relate its needs and emerging program effectively to the existing health and social welfare agencies of the city. Later on he lined up agencies to handle training of the first batch of para-professionals who were hired. He was the Health Committee's choice to be Master of Ceremonies at the opening of the center.

The performance of Buxbaum, Sargent and other professionals from outside the parent corporation was a critical ingredient. By securing the support of key local actors and federal officials, they were responsible for a large share of the early successes required to get the Center off the ground. Perhaps as significant as their individual talents and commitments was the fact that, with the exception of Roger Steffen, they were all outsiders, operating under the auspices of OSTI or various city agencies. The outsiders status of this group could have been a real stumbling block to garnering the necessary local endorsements, but the consultants were sensitive enough to allay any suspicions which local persons might have had that they were intruding foreigners. The external base of their involvement made it much easier and more natural that their roles faded out as the tasks which they performed were not longer necessary because the program was reaching later stages of development. For instance, Sargent commented several months after the Center opened: "Right now I'm not sure what my role is supposed to be. Once in a while I come to meetings. I try to make myself available, but I haven't been asked for anything since Henley and Dr. Dugas were

hired. I have dropped out of the picture."[17] From his vantage point, this turn of events seems natural, even desirable. He misses his earlier intimate connection with the program because he enjoyed working with the people, but he has no apparent desire to hang on. Steffen's rather unique function within the YDCC -- that of a sort of freelance planner -- permitted him to switch to other responsibilities once the Center was firmly underway. In addition, Steffen is firmly committed to the ideology of community control and deliberately kept himself in the background. He was leaving the YDCC just as this study was made. Stauffer had a job with another local agency and remained at it once the Center was open. Jim Howard took a job teaching at a medical school in Michigan.

In addition to Buxbaum and company's appearance on the scene, the critically important function of jettisoning the initiators at the appropriate time was facilitated by the organizational structure of the YDCC. The YDCC framework of a set of Core Services, including basic overall administration, which was linked to Component Services, provided a strong form of geographic and administrative decentralization within the program itself. YDCC Core Services staff who worked on the Health Center in the planning stage were never in the position of being directly involved in implementing the plan or of having a chance to take it over.

This line of argument does not seek to imply that the initiators of innovative programs should necessarily be removed shortly after a program is underway. There are a number of

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[17] Ibid.

neighborhood health center administrators who have worked successfully in planning stages of development and have stayed on to manage the programs successfully through early and later phases of implementation. However, the more general experience has been one of rapid turnover of program directors and other administrative staff. The imperatives of organizational development inherently undercut the staying power in the initiators.

In the process of planning for improved health services in Yeatman, representatives of different medical associations and health agencies were invited and appeared before the Health Committee in a steady flow. These appearances served the dual functions of soliciting the support of the respective groups represented and impressing upon them that the Yeatman Health Committee meant business, that the proposed Center was indeed going to become a reality if the dedication of its supporters had anything to do with it.

Of the two local medical schools -- Washington University and St. Louis University -- St. Louis University was more interested and helpful in getting the program underway.[18] Dean Felix was in the process of establishing a Department of Community Medicine and an affiliation with Yeatman meshed with his needs in this regard very well. Dr. Max Pepper was recruited to head this Department just as Yeatman was acquiring funds for the Center.

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[18]For a description of Washington University School of Medicine's lesser involvement in providing health services to the poor in St. Louis see Ralph Freidin, Robert Levy, and Robert Harmon, "A Student-Community Planned Health Project for the Poor," The New England Journal of Medicine, Vol. 283, No. 21 (Nov. 19, 1970), pp. 1142-1147.

The composition of the Health Committee was skewed from the start. OSTI Consultant Kay Keiser reported following her April 1968 visit to St. Louis: "The Health Committee ... is composed of a group of elderly, well-intentioned, and pious black women. Its composition should be changed to include some younger and more aggressive individuals."[19] The composition of the Health Committee and the Board had always seemed unrepresentative to the OSTI staff, whose notions of appropriate strategies for effecting social change require a more conflict-oriented group of residents. These assessments of the composition of the Health Committee may be fair with regard to the question of representativeness, but they seriously underestimated the talents of at least some of the Committee members. Within the Committee were a number of women of extraordinary commitment, determination and political intuition, strong on relating to their own in the community.

The concerns expressed most strongly by Health Committee members during the planning period were that the Center deliver services (1) given by a doctor who was sincerely interested in them, and (2) delivered with reasonable speed; that (3) services be available to all members of a family in one place, (4) transportation when needed be provided, and (5) the center be open convenient hours.[20] In summary, then, they were more concerned with aspects

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[19]Kay Keiser, "Report of Site Visit to Yeatman, April 23, 24, 1968," a memo to the Organization for Social and Technical Innovation, Cambridge, Mass., p. 8.

[20]Sargent interview, May 6, 1970.

of the delivery of services than with the services themselves. They assumed that competent professionals hired to provide health care would adequately handle the content of the services.

By April 1968, Buxbaum was in firm disagreement with the directions of development desired by the local HEW office. He wanted to proceed at a slower pace which would allow the Health Committee to grow smoothly to its full potential. HEW was pushing for more immediate programmatic accomplishments. Buxbaum reported:

> HEW evidently wishes to have us act more rapidly, to provide more services sooner, and to solve the problems of the slum for its occupants. I take, on the other hand, our mission to be the development of viable community institutions, of which health services are examples, through the encouragement of community-controlled and initiated programs.... We are told to use the funds soon, or they will revert back to some other program. Well, I am not sure we should not allow this to happen, while we proceed with our own organizational process.[21]

The YDCC wanted to accept HEW funds as soon as they were offered.

The reports of OSTI consultants throughout 1968 presaged absolute and unavoidable doom for the proposed clinic. As events unfolded, however, many of the difficulties which they foresaw were taken care of or disappeared along the way. OSTI consultant Kay Keiser was distressed with the paucity of hard data about conditions in the District upon which plans were being carried forward, a complaint reminiscent of the earlier objections to the proposal voiced by established medical organizations and agencies, although her concern

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[21]Organization for Social and Technical Innovation, op. cit., p. 45.

was founded on a desire to see the Center speedily implemented.

The original plan and the initial grant of $341,000 were intended to finance the provision of health services in the evenings, to be delivered out of the Jefferson-Cass well-baby clinic run by the city. The city Health Department had agreed to allow the use of its facilities for this purpose. Kay Keiser stated in a memo to OSTI that this direction of development would have irreparable negative consequences for the health program. The proposed interim services arrangement was hopelessly fragmented and discontinuous in its coverage. Implementation of the interim proposal would retard progress toward a more comprehensive program. Another OSTI consultant concluded at this stage that of the many community corporations interested in developing neighborhood treatment centers in St. Louis, the Yeatman Corporation contained the most numerous inherent obstacles to success. His report concluded that the ideal of comprehensive care would be impossible to achieve through the proposed program operating out of Jefferson-Cass, which, if implemented, would be an obstacle to eventual accomplishment of that goal.

In the middle of 1968, with its original grant in hand, the Health Committee was struggling with the question of how to proceed toward their stated objective of providing health services on an interim basis. At the same time they were completing plans for a comprehensive neighborhood health center. They were suffering badly from lack of a full-time staff. Their search for a Director of the Health Center elicited applications from across the country,

but the man they were looking for appeared one night quite by accident A. J. Henley, a black pharmacist at the Homer G. Phillips Hospital, as a favor to a friend, substituted for him to talk to the Health Committee one night. The Committee was immediately impressed and his interest in the project was captured. He was hired and soon afterwards secured the services of Dr. H. Dugas as Medical Director of the Center.

By the time the HEW funds finally arrived, in late September 1968, it was too late to spend all of the grant on the items specified in the application. This gave Henley all the opening he needed to convince the Public Health Service to allow $50,000 of the money to be spent on renovating the building which the Center now occupies. The Center never did operate out of the Jefferson-Cass maternal and infant care facility. Reflecting on the first proposal, the current administrator of the Center comments, "It would never have been refunded. We felt it was just enough to let us fail on."[22] Instead, Henley directed his energies and those of the Health Committee toward establishing a permanent Center. A building was rented and rehabilitation begun. Recruitment of staff followed and several workers canvassed the neighborhood to seek out residents' health needs and to interest them in using the new Center once it was completed. Finally, in September 1969 the Yeatman Health Center opened for business.

In establishing the Health Center, consumer representatives in Yeatman made little use of coercion or overt protest as a mode of

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[22]Personal interview with A. J. Henley, St. Louis, May 5, 1970.

other ideals which the doctor held in his professional role. Buxbaum was able to overcome objections which derived from the doctor's position with a government agency, and the pediatrician was very helpful later on in the planning process.[23]

By a combination of good luck, fortunate timing and the complexion of the local political scene at the time, the YDCC and later the Center were able to garner for themselves a substantial amount of authority. This authority consisted of legal powers of action spelled out in the Corporation's articles of incorporation and fairly direct access to federal funds. There is some evidence that city authorities permitted the Health Center to be established without being fully aware of the degree of authority and autonomy granted to the group charged with running the new facility. At the time when the Yeatman Health Center was being planned, Dr. Herbert Dombke, Director of the Department of Health and Hospitals, and Dr. J. Earl Smith, the Health Commissioner, were engaged in a power struggle which drew their attention away from new developments such as the proposal for a neighborhood health center. Yeatman residents and Center professionals feel that because city officials realized later the amount of authority they had signed away, they have resisted more vigorously the efforts of other poverty neighborhoods to develop similarly autonomous service institutions.

Supporters of the Yeatman Health Center have been able to pursue the strategy of bargaining as opposed to protest politics by

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[23]Personal interview with Dorothy Stauffer, St. Louis, May 8, 1970.

skillfully accumulating negotiable resources and by shrewdly identifying areas of mutual self-interest between themselves and the agencies of government and public service organizations whose active support or passive endorsement they required.

Henley's personal style of administrative maneuvering exemplifies that of the whole program. It is basically a consensus, as opposed to a conflict, orientation. Henley explains,

> We've accepted the fact that one must learn to outmaneuver, to negotiate with one's opposition. That this works better than going out hollering and screaming. We try to out-think -- this is how things are done here.... Rather than threatening, telling people what their obligations should be to us, we think in terms of what is that we have that they need.[24]

He points out that other organizations who have gone the route of overt conflict and confrontation have failed.

For the St. Louis University Medical School, the Yeatman operation potentially represented a community involvement that satisfied a variety of institutional needs. The link is undeniably helpful in soliciting various types of federal funds. It provides a context for more modern, up-to-date teaching, if not research. (The Health Committee has resisted overtures from local universities to use the Center for research purposes.) Students demand relevance and community medicine. Yeatman has got it. None of these qualities or institutional objectives appears to have been manipulated in any opportunistic way by the Medical School. On the contrary, these

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[24]Henley interview, May 5, 1970.

institutional interests are pursued and expressed by individuals whose personal commitment to them is founded solidly in humanitarian ideals and instincts. Dr. Max Pepper, head of the Department of Community Medicine, is an impressive personalization of this point.

To the Public Health Service at both the regional and national offices, the Yeatman project emerged fairly early on as a potential gem. The Center had all the makings of a national showpiece. It promised to be -- and to date that promise has been fulfilled -- an operational example of community control unaccompanied by the boiling factionalism and political sniping common to such experiments.

It can be argued of course that all this evidence of governmental support for the Yeatman experiment is fine and good, but it rests finally on the assumption that it is a demonstration project and no more. The organizational arrangements expressed by it can easily be tolerated in small doses or in relative isolation from other medical programs and institutions, but would be firmly opposed by established medical institutions and associations if attempted on a broad scale.

There was, on the other hand, no visible quid pro quo in the offing for the Department of Health and Hospitals to go along with the project except the general consideration that the Yeatman facility would relieve some pressures on the Department to provide more and better services than it has in the past. There is no clear evidence, however, that the Department was motivated by this factor any more than by the opposing motivation of organizational imperialism.

The demand for community control in the Yeatman Health Center was less of a battle in its own right because the parent corporation

was already established with a strong framework for that mode of operating. It was only logical that the neighborhood health center as a component program operating within this same context should be characterized by community control as well. There was some resistance to the establishment of a community-controlled center on the part of established medical operations, but their opposition proved to be short-lived.

The motivation of Yeatman residents for community control of their health program was founded primarily in acute dissatisfaction with present health conditions in the District and with the existing health programs and facilities available to neighborhood residents In addition, consumer representatives were motivated by a desire for increased group power. In some ways this specific instance of defining and institutionalizing community control of the neighborhood health center was an extension of the civil rights and black power movements. It represents a very concrete, highly visible and symbolically important example of black citizens acquiring control over a public service of vital significance to the neighborhood. In the words of one YDCC Board member, it is "the most vivid example of proving the citizen role."[25]

YDCC staff and Board members and OSTI staff as well all held objectives for the Center which extended beyond the provision of health care services. They saw the program as an integral part of

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[25]Personal interview with Mary Short, St. Louis, May 7, 1970.

an overall strategy to develop the neighborhood economically and politically, to wrench it out of the poverty cycle. The acquisition of group power centered on a geographical area was a basic objective of the Health Center effort. Health was being seized upon as an available wedge to get other programs and activities moving, as well as a means of accomplishment in its own right. The services rendered would make residents more readily employable. The Center would be a significant source of jobs for area residents. The process of community organization around the facility and its services would feed into a broader mobilization of neighborhood residents in addition to securing their inputs to health issues in particular.

It is necessary to distinguish between the accomplishment of community control at the Yeatman Health Center and the functioning of control once the structuring of authority which constitutes community control was set. Community control was accomplished in the period of planning, through the logical extension of arrangements pioneered by the parent corporation and in the establishment of the Center itself. The arguments pro and con control and the political pressures connected to these positions were expressed most forcefully at this earlier stage of development of the program. Given the accomplishment of community control, the issues and functioning of consumer involvement have taken on an appearance very similar to the consumer participation model.

OPERATING THE YEATMAN HEALTH CENTER -- PROBLEMS OF IMPLEMENTATION

The tasks undertaken by the Yeatman Health Committee since the Center has opened resemble very closely those performed by many other health consumer councils under the rubric of participation rather than control. The activities which occupy the time of the Committee overlap substantially with those which claim the attention of Denver's Eastside Health Board and other neighborhood health center consumer groups. This similarity of tasks performed is to be expected since community control is, after all, an extension of consumer participation. Community control is more of the same, plus some. The Yeatman Health Committee has helped to recruit staff applicants. Members have spoken at neighborhood and city-wide meetings to publicize the Center and to urge eligible persons to make use of its services. They have worked to define precisely the concerns of potential patients. Their ideas have generated programmatic shifts from time to time.

The key contrast in terms of work activity of consumer representatives lies in the realm of policy formulation. Health Committee members in Yeatman are formally responsible for setting policy for operation of the Center. Under the consumer participation model, they would only advise on policy decisions. Although the providers in Yeatman often determine the course of policy debates through their full-time attention and greater expertise, the consumers' group is the ultimate source of authority on policy questions. The content of policy discussions in Yeatman has resembled closely those at the Eastside Health Center, but the tone has been different. This

difference in tone is subtle, but highly significant. When the Department of Health and Hospitals in Denver has consulted the Eastside Health Board all parties have recognized throughout the interchange that the Department has the legal authority to pull things its way in the last analysis.

The opposite situation obtains at Yeatman. A. J. Henley may have a firm grip on the Health Committee's direction, but he is constantly aware that they can bypass his suggestions and force their own will to be imprinted as policy. He is aware also that they may fire him for refusing, or being unable, to implement policy as the Committee enunciates it. This situation creates a curious and delicate balance between manipulation and respect on the part of the Administrator of the Center. He knows quite well how to get the Committee to do his bidding, but he is aware that he cannot always do so.

Henley feels that "It's just like working for anyone else." "I do my job. I recognize lines of authority and try not to overlook anybody."[26] The Health Committee could make things hot for him, but they do not. Henley is careful and skillful in his relations with Committee and Board members. By virtue of his greater expertise and full-time involvement with the Center's activities and functioning, he is able to get what he wants out of the Committee almost all the time. One the other hand, the Committee and Board's ultimate power is still there although the full extent of it is not exercised, so

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[26]Henley interview, May 5, 1970.

long as they are satisfied. Because Henley is a good administrator as well as a smooth diplomat, they have had little cause or opportunity to flex their muscles yet.

Some matters brought before the Committee are dealt with with such dispatch and routine that the group seems to be a real rubber stamp. However, it is often the case that items on the agenda spark considerable debate and sharp questioning. In one meeting in the spring of 1970, for example, the Vice-Chairman of the YDCC took the Center staff to task for overlooking the applications already on file of two District residents when the Center was trying to hire two additional nurses. Henley acknowledges that this sort of watchdogging and questioning by the Committee keeps him on his toes. The meetings of the YDCC Board are even more unpredictable as to when the Center's administration will be challenged.

In order for the administrators of the Center to maintain their respect for the Committee's powers, the Committee does need to assert its prerogatives occasionally. It does not assert itself very frequently, however. It does so much less often than some other controlling boards choose to. At times it appears that their governing strength has atrophied and that community control on paper means, in practice, control by neighborhood level bureaucrats. In part this may be because Henley and his staff give them few openings, in part because the program is still in earlier stages of implementation, and therefore the problems of transition to later stages of program development and the new organizational demands of these later stages are only beginning to be felt.

A crucial element in this balance between manipulation and deference is Henley's policy of bringing to the Committee and to the Board administrative matters which he could very likely handle on his own. He goes to considerable pains to seek their advice and counsel on matters which he could do himself without their help and for which he would not be criticized if he did not seek their advice. This tendency is more a factor of personal administrative style than a result of community control *per se* as a form of organizational arrangement. It gives the Committee something meaningful to do and enables Henley to cover himself, protect himself from a variety of potential future criticisms. As Henley reveals,

> The truth is that I'm afraid not to go to these meetings. If I'm not there and they fail to bring up a personnel matter or something else, I've lost two weeks on the matter.[27]

A good example of this style and mode of consultation occurred at a Committee meeting in May 1970. Henley announced that the YMCA wanted the Center to give physical examinations to 800 boys who would be in a work incentive program over the summer. The Y would pay $10 a head for the job. As Henley put the question, the Center could use the money, but what would be the costs to the ongoing operation and are these costs worth the extra cash? Doctors were willing to do the job, but it would mean giving them time off another time, which could deprive some persons of an appointment at a later time. Committee members responded by stating that the Center should not cut any corners if the job were taken on, but should give thorough

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[27] *Ibid.*

examinations. Dr. Dugas, the Medical Director, reported that the equivalent of one physician work week would be required to complete the work. Presented with this information and Henley's reservations, the Committee let the matter ride for the time being, but with a feeling of having been fully involved in the decision.

The Committee does not hear directly about all phases of the program's operations or about all ongoing planning. For example, the innovative work of the public health nutritionist at the Center is communicated to A. J. Henley and included in his reports to the Committee, but the woman in charge of these does not report to them. Dr. Larry Millner, who is the one full-time person working on development of a pre-paid insurance scheme for the program, attends meetings regularly, but he comments, "I tell them whenever something good happens, but they don't know enough about prepayment to raise any concerns really."[28] Millner reports that resident input was solicited about the household survey being planned for the area by showing them sample tables of what could come out of it. The approach failed, he said, because the tables were of no direct use to the residents and because they could not understand them.[29]

Consumer representatives have been most keenly interested in non-medical matters. This was true during planning, but is even more pronounced now that the Center is functioning. They have a

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[28]Personal interview with Dr. Larry Millner, St. Louis, May 6, 1970.

[29]*Ibid.*

sharp interest in the practice of medicine, in its substance as a professional discipline, and they have learned quickly about it. However, the focus of their attention as a decision-making policy board has been upon aspects of the operation of the Center which are quite distinct from the practice of medicine.

Concepts of health care articulated by Center administrators and staff seem to indicate little if any need for consumer participation as a vehicle for engendering greater sensitivity on the part of providers to patient needs and wants. The Center bends over backwards to please patients, to attract new ones and to encourage them to follow prescribed treatments and to come back when recommended. The social service unit "holds that if treatment is to be effective it must deal with the whole man as he interacts with the community's institutions, the family and himself."[30] The Center places a high value on the special skills of the paraprofessional in relating to patients; the staff express a sincere belief in this concept. "Yeatman assumes the paraprofessional can handle more than what is usually thought."[31] In a sense, the paraprofessional is a consumer representative and supplants the consumer representatives in many of their functions. On the other hand, the only complaints made by patients in the first year of operation were directed at the behavior of some paraprofessional staff members.

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[30] Yeatman Health Center, op. cit., p. 39.

[31] Ibid., p. 41.

The Director of the Center relates that his views and those of the staff have changed somewhat about the kind of health care desired by Yeatman patients. He originally maintained an expansive, idealistic conception of what patients wanted. His views have changed dramatically, for he now feels that a patient most of all

> doesn't want to have to wait. He wants to be treated with dignity and wants to have his own doctor. Past that, all the other hangups are mine -- what I think they want and need... the idea that a patient should see the same social worker, the same neighborhood aide, the same lab technician, etc. on each visit ... this isn't the concern of the person sitting in the waiting room. It's a concern of professionals on paper.[32]

The Mental Health subcommittee of the Health Committee was formed shortly after the Center opened. It advises the Malcolm Bliss Mental Hospital which provides mental health services through a newly established Community Mental Health Program and provides two psychiatrists to the Center on a part-time basis. The Subcommittee has succeeded in increasing the hours of psychiatric care being made available at the Center each week, communicated dissatisfaction with the performance of a foreign psychiatrist, urged and obtained the hiring of a black psychiatrist, and achieved revision of the tests required of residents applying for work.[33]

The experience of the Center staff in dealing with the Health Committee mirrors the consultants' policy earlier on of standing back

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[32]Henley interview, May 5, 1970.

[33]Yeatman Health Center, op. cit., p. 3.

from their deliberations. The "Progress Report" remarks, "Participation is always hampered by too much professional input."[34] A professional advisory committee was established to provide the Committee with expertise and advice they needed without involving Center staff in this role. "Many decisions involving evaluation, prepayment, health education and other problems found residents lacking the expertise to make decisions and participation began to lag"[35] just as the Center opened in September 1969. This professional advisory group is currently dormant but stands ready when called.

In the early months of 1970, the Health Committee was suffering from a sharp decline in interest on the part of residents. A special meeting of the Board of Directors was convened in March "to give help and assistance to the Health Chairman, Mrs. Arabella Lawrence" because the Health Committee "is not functioning to its fullest capacity."[36] Attendance had fallen off. Center employees who were on duty were coming to the Committee meetings.

At the Board meeting, members were encouraged "to encourage residents to participate in health meetings, so staff will be relieved of this duty."[37] This continuing concern has remained largely at the level of exhortation rather than effective action. At the time of this study, there was no one on the staff of the Center

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[34] Ibid.

[35] Ibid.

[36] "Minutes, Special Health Meeting, YDCC Board of Directors," St. Louis, March 10, 1970.

[37] Ibid.

or the Corporation assigned to follow up persons who showed some interest in the Health Committee in order to nurture their continuing involvement.

The composition of the Board of Directors in some ways exemplifies and in others differs sharply from the population profile of the District as a whole. The majority of members of the Board, and to a greater extent, of the Health Committee are women approaching or beyond middle-age. Male participants are mostly ministers and retired men. Representatives of younger segments of the community, the unemployed and middle-aged men are almost entirely lacking. Obviously, the predominance of women is accounted for only partly by their 55:45 supremacy in the sexual ratio of the area. The older-age bias of the Health Committee was further accentuated when approximately ten of the active original members were hired to the staff of the new Center.

Mrs. Arabella Lawrence, the venerable head of the Health Committee, has been a great source of strength and leadership, but she is less capable in handling the Committee meetings effectively. When Center staff and other Committee members decided that it was desirable to make her emeritus and suggested adding a co-chairwoman, she became upset and the reformers backed off. It is extremely difficult -- well-nigh impossible -- to envision a change in this position because of who the chairwoman is and the universal respect with which she is held. For years, she has worked as a janitress for a group of doctors in town. Now she has helped to establish an innovative, nationally recognized health program in her neighborhood. Her

picture adorns a poster prominently displayed at the reception desk of the Health Center. Many Committee members would be unable to let themselves allow her to be forced to step down. A move against her is in some ways an affront to all of them because she symbolizes many of the values and fine qualities of the membership -- in her dedication and religious devotion. The problem of making a transition in the leadership of the Committee is inextricably linked to the broader issue of the composition of the whole group -- predominantly older women and a few elderly men. The pervasive layer of sentiment which surrounds the group and which the currently active members embody has been an important driving force for the program. It has sustained the Committee well through a lengthy, arduous period of planning and delays in opening the Center. On the other hand, the strength of these personal attachments and the common bonds with the religious institutions serve also to keep the structure closed to outsiders. One staff member commented that younger people who might potentially be involved would be discouraged by the conservativeness of the Board (and Health Committee).

The dozen members of the Health Committee who were hired by the Center can continue to attend Committee meetings, but are not allowed to vote. These former Committee members are a very able group of women. They include persons who have worked hard for the Center since the start of planning, such as Tillie Alexander, a mainstay of the Committee and now Administrative Assistant to the Director of the Center. The Committee realizes that it needs new

members and encourages all newcomers to join up. Patients entering the Center are asked whether they would like to serve on the Committee. Recruiting new members is no easy task and these efforts have not yielded many new participants. The January 1970 "Progress Report" states clearly the Center administration's commitment:

> We feel that the best judges of care rendered at the Center would most certainly come from recipients of that care....
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> Maximum efforts have been applied to convince residents that the Center is theirs. Many doubts existed during the first stages of operation that are now being dispelled. Certainly these doubts were evident earlier in that residents had very little to say when they came to the Center. This has changed remarkably in the past three months. Compliments and constructive criticisms are received daily by area residents, as well as suggestions for meaningful changes....
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> Residents are being made aware that their opinions are heard and that they are in a position to implement changes.[38]

This is an explicit recognition of the vast difference between "consumers" and "consumer representatives." Consumers are by no means vocal participants without substantial and sustained encouragement.

The substation health committees, always subordinate to the District-wide Health Committee and never particularly active, have withered since the Center opened. The original plan called for the substation health committees to merge, but it was decided not to force their integration. New members were recruited directly to the Center's Health Committee instead, and the substation committees

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[38] Yeatman Health Center, op. cit., p. 2.

continued to function on a limited basis with declining support. They have been concerned mostly with issues of health education because staff members working out of the substations are in the Social Services division. By the spring of 1970 only the Cottage substation health committee was functioning with any regularity and it included only 7 or 8 persons. Center staff regularly attend the meetings of the Cottage Station Group and representatives of that committee attend Health Committee meetings. The reason for going slow on the merger lay in the none too stable existence of the substations. As one staff member put it, "You have to understand the importance of group meetings to the reports of the substations -- this is one of the things they do, that they can claim as a reason for existing."[39]

At the high water mark of their operation, the staff at each station included a supervisor, two community social work assistants and four general outreach persons. The Health Center has used these persons as a network to disseminate information from time to time; however, the financial squeeze experienced by the corporation in 1970 reduced the number of outreach workers and thus rendered these units less important to the Health Center.

It is ironic that the Center administration's views on, and concerns with regard to, the involvement of residents sounds more like a response to consumer participation than to community control.

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[39]Personal interview with Geraldine Binion, St. Louis, May 8, 1970.

There exists a considerable gap in Yeatman between the standard myths with regard to what community control means and how it in fact works. The expressed concerns of Center administrators enunciate a rationale for consumer influence which is closer to consumer participation than to community control. Community control is a fact in Yeatman, but it has not meant the presence of a strong band of militants breathing down the necks of the program administrators. Quite the contrary, the Health Committee and the Center's administrators have to work hard to stir up residents' interest in active involvement in policy-making. They worry about the difficulties encountered in convincing the residents that the Health Center is really theirs, that they can affect its policies. Hence, for the bulk of the patient population of the District, community control is now more a potentiality than a reality in terms of their individual contacts with the operation. On the other hand, it is true that community control is, in this case, strongly expressed through a representative system, although only a fraction of the eligible voters exercise this right in the elections of Board members.

There had been three elections for membership on the YDCC Board before this study was undertaken. The first in 1967 attracted a turnout of 1800. The following year only 900 persons voted, and in 1969 the total votes cast increased to 1200. Since the YDCC has had a relatively constant membership of 18,000, this means that 10%, 5%, and 8% of those eligible to vote have done so on successive years. Al Lynch, YDCC Executive Director, has been disappointed by these

turnouts, but feels that poor weather on all of the election days to date held down the totals somewhat. The voter turnout figures are small, but they compare favorably with those of many CAP elections across the country. The YDCC Board elections seem to be more a part of a solid system of representation if one looks at the number of candidates who have run. An average of 35 to 40 persons run for the 15 seats allocated to each subdistrict. Usually they form slates which work together. The campaigning is vigorous and election posters and literature decorate the district for a month before the votes are case.

The goals held by health providers and consumers for community control in Yeatman cannot be distinguished into two consistently separate sets of functions and objectives. To some extent the unified range of objectives is due to the dual roles that several key actors in Yeatman play, which cast them as both providers and consumers. Complementing this situation is the fact that the ideology of community control as opposed to consumer participation defines the distinction between provider and consumer in a way which diminishes or controls the tension over goals. The experience of Yeatman seconds the notion that community control is, as its proponents argue, a more stable assignment of responsibilities and a more definite or acceptable designation of authority over different aspects of a program. Because the whole question of the limits of consumer participation has already been answered, the provider-consumer differences about proper functions and objectives for

consumer involvement are not regularly expressed. They are not on the menu of continuing policy debates with regard to the Health Center.

The prime instance of persons crossing the consumer-provider line came when a group of Health Committee members applied for and were given jobs at the Center. These women are now health providers, technically speaking, but they remain consumer representatives. They continue to live in Yeatman, many of them continue to attend Health Committee meetings, although they can no longer vote. They carry with them in their work a consumer perspective dominated by the same concerns which motivated their original involvement with the Health Committee.

A second active agent in the blurring of the consumer-provider distinction, as defined by the objectives and functions held for consumer involvement, rests with the character of the professional staff of the Center. About one-half of the doctors are black. Although by occupation they are solidly upper middle-class, they identify to varying degrees with the black revolution. Their concepts of appropriate consumer representation and involvement overlap significantly with personal notions of the problems of blacks in this society. The prerogatives of health consumer representatives in Yeatman is an issue not entirely separable from the larger question of the position of blacks in this society. Community control in this instance is not merely a readjustment of the provider-consumer balance but a definite, although highly tentative and limited, redistribution of power among racial groups -- from white to black -- within St. Louis.

The fact of community control structures the program so that health providers have a self-interest in protecting the power entrusted to consumer representatives rather than taking pot-shots at it. These professionals owe their jobs to the Health Committee and the YDCC Board Personnel Committee. This pattern of health provider interests contrasts sharply with the consumer participation model where the power to hire and fire, and therefore the ultimate allegiance of health providers, rests with other providers. Health providers in Yeatman do maintain a steady commitment to professional ideas. Their professional status is important to them. The set-up does not challenge this status, however, because they retain control over medical matters and have a large actual share of control over the total operation of the Center by virtue of their close relationships with consumer representatives and their ability to persuade consumer representatives of the correctness of their ideas and positions on issues.

The consumer representatives in this instance of community control stress the same functions and objectives articulated by consumers whose involvement does not extend beyond "participation in" decisions to "control over" them. Health Committee members emphasize most strongly the benefits of community control which accrue to the program itself and to their community. They acknowledge the benefits enjoyed by individual participants, but do not dwell on these as especially important in the set of functions involved. Members of the Corporation and of the Committee realize the social satisfactions which individual persons get from taking part in Yeatman

health planning, but they do not conceive of the work of the Committee as good therapy for local senior citizens. Yeatman consumer representatives are keenly aware of the advantages of involvement and control to individual participants and participating groups as a way of building skills in community organization and providing training which has usefulness in political situations beyond the immediate substantive activity. Consumer representatives have faced some of the difficulties attributed to community control and have solved them, at least for the time being. The few instances of consumers meddling in staff affairs or intervening in supervision of routine operations have been censured by the group.

There is a strong sense among Yeatman Health consumer representatives that they are "showing how it can be done." They perceive a direct demonstration value of the program, including the efficacy of community control as a level and scope of consumer involvement. A staff member who was formerly a consumer representative commented about the National Conference of Health Consumers held in Berkeley, California in October 1969: "I came away thinking we've been giving, but not taking back much. Sometimes people at the conferences don't believe us [when we say what we have been able to do]."[40]

Functioning under a system of community control has enabled the Yeatman Health Center to avoid a whole set of disputes character-

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[40]Personal interview with Tillie Alexander, St. Louis, May 5, 1970.

istic of neighborhood health programs whose patient inputs are limited to consumer participation. The presence from the beginning of a full measure of community control removed as an item of contention the tasks of distinguishing between consumer and provider responsibilities. Community control in Yeatman has not eliminated these difficulties entirely, but has reduced them substantially. In Yeatman, there can be no movement for more power on the part of health consumer representatives because they have it all already. There can -- and probably will at some point -- be intense internal conflict among groups within the District over who will control the program. The founding of the YDCC was marked by a period of bitter struggle between members of the Jeff-Vander-Lou Corporation and persons associated with the old Yeatman Neighborhood Center run by the H.D.C.

As a direct result of community control, a whole realm of potential conflicts with outside health agencies does not exist. There remain substantial opportunities for bitter struggle with municipal and private health institutions, but not over issues related to the basic functioning of the neighborhood health center. The Health Center may lock horns with local hospitals over referral arrangements and doctors privileges at the hospitals, for example.

Community control simplifies the organizational structure of the program. If the neighborhood health center were run by an agency from outside the Yeatman area, consumer participation or community control -- whatever level and combination of consumer involvement -- would necessarily relate to this outside agency. In addition, the

presence of an outside administering organization can be a hugely complicating factor because it may embroil the representative consumer group in the host of political entanglements which confront that outside organization.

In formal structural terms, the Yeatman Health Center is supervised by a larger, more encompassing organization, the YDCC. However, the Center is for all intents and purposes quite independent because the YDCC guarantees a solid amount of decentralization of its component programs, and also because the Health Center is a bigger operation, has a larger budget than the rest of the YDCC.

A primary reason for the relatively low amount of provider-consumer conflict surrounding the Yeatman Health Center has been the nature of the constituencies to which providers and consumers there relate. As was described earlier, the Yeatman health professionals relate to a broader range of constituencies than is the case in programs which limit consumer participation more severely. Their relationships to the diffuse professional constituencies composed of their professional colleagues working elsewhere and defined by the boundaries of the profession with which they are associated, are either attenuated or else the professionals have a relatively secure niche within the professional avant-garde or more innovative, change-oriented segments of the profession. This serves to isolate them from elements of professional tradition which militate against lending steady support to strong consumer participation or the accomplishment of community control. Yeatman

health providers, the professional consultants who assisted in the planning period, and allied professionals working for other agencies in the city maintain a type of relationship with the Yeatman health consumers which makes that population a quasi-constituency. The Yeatman health provider groups hold values not only for the quality of medical care dispensed, but also for the desirability of community control. This commitment sustains a bond between them and the consumers. They interact with actual consumers and with consumer representatives more frequently and intensively outside of the doctor-patient setting than do most other health professionals. They look to consumers for some of their working cues. The response of consumers and consumer groups to their work is for them a highly important source of personal satisfaction. They play to that constituency in ways which are not visible -- in a sort of implicit dialogue or communication. These consumer-oriented providers also owe their jobs directly to a group of consumers. Their employers cannot be defined as constituents, but the broader group of consumers who elect the Board from which the representatives are drawn, does serve as a constituency for these people. In looking at the Health Committee, they see beyond it the whole patient population. A number of the doctors hope for and treasure a kind of relationship with this population which is dramatically at variance with the traditional authoritarian stance of the doctor in the doctor-patient paradigm. In a sense, they share with members of the Corporation Board and the Health Committee, the users of the Health Center as a constituency, although the consumer representa-

tives' ties are much more direct and a more exclusive source of satisfaction and legitimacy. This sharing of constituencies goes a long way toward mitigating any potential conflicts between providers and consumers.

While it is extremely difficult to trace the implications for broader change of health systems which derive from community control in this case, some effects can be seen. Since the Yeatman Health Center opened, the patient load at Homer G. Phillips, the municipal hospital most heavily used by Yeatman residents, has dropped somewhat in the outpatient clinics but not in the emergency room. The effect is not clear-cut or long-term enough to attribute it with complete confidence to the existence of the Center and to community control.

Getting the Center established involved a series of encounters -- some of them conflict-laden and threatening -- with local medical institutions. As the program develops, changing organizational needs are feeding new conflicts. The question of long-term financing is a good example. In trying to provide for eventual financial self-sufficiency, the Center would benefit from a revision of Medicare legislation to include the Part C provisions considered but not passed by the 91st Congress. This involves the director of the pre-paid planning effort in writing letters to Medicare administrators, soliciting the views and support of other neighborhood health centers across the country, and general lobbying in support of the modifications. Other incremental changes being worked on in this area include trying to convince the Missouri Department of Welfare

to permit flat fee reimbursement to the Center for services to Medicaid patients rather than continuing the current policy of reimbursing only individual doctors -- a practice which is inefficient for the Center to comply with and which artificially inflate the income of the staff physicians, who are reimbursed and turn over the checks to the Center.

The existence of the Center does present local hospitals with a dramatic illustration of a new way of operating, of a successfully functioning alternative form of public practice. It relieves pressures on public and private institutions to be doing more for Yeatman patients, but builds up at the same time pressures which impinge on major medical institutions in that direction. Yeatman residents can and do go to the Health Center for primary health care. This new source of care meets a previously unmet, or less than adequately met set of needs, but it creates new demands for health care as well. The simple fact of obtaining high quality care for the first time reorders for hundreds of Yeatman families their whole sense of what is possible in the way of treatment and prevention of disease. This evolving consciousness gradually but surely translates into a growing recognition of health care as a basic right of all persons and to the forceful expression of this right. The Yeatman Health Committee directs a great deal of its energies inward, but this group along with the Center staff speaks to the broader medical community in St. Louis with heightened confidence about changes in the policies and programs of other health agencies and institutions which are essential if this right is to be honored and fulfilled.

Providers and consumers alike in Yeatman uniformly express wonderment at what they consider to be the fortuitous set of developments which led to successful establishment of the Center. One observer claimed that it was "doomed to success." There is a shared mystification about why events proceeded as they did despite a common recognition of the hard work of many persons, the specific planning activities and political spadework undertaken toward that end. Most prominent among the list of "accidents" specified are Regional HEW's support for the proposal, the city government and city Health Department's failure to block it, the recruitment of a strong Center director and staff.

This attitude probably is both created and sustained by the religious faith of individual participants and the Yeatman area as a whole, but it flows also from local actors' lack of previous association with so solid an accomplishment in the way of a publicly sponsored program.

ST. LOUIS - CHRONOLOGY OF MAJOR EVENTS*

January 1967	St. Louis designated as a Neighborhood Service Project City
June 23, 1967	Approval of NSP I received
Summer 1967	Intra-neighborhood struggle for control of NSP
July 1, 1967	Start of OSTI contract to provide technical assistance to the YDCC
August 31, 1967	Elections held for Yeatman Neighborhood Advisory Council, Interim Board selected
September 5, 1967	Newly elected NAC meets and forms YDCC
October 1967	Intensive program planning committee meetings to develop NSP II; Health section criticized by medical agencies.
December 5, 1967	Buxbaum's first meetings with Health Committee.
January 3, 1968	Alphonse Lynch, Coordinator of Yeatman Center HDC hired as YDCC Executive Director by the Interim Board; other staff of Yeatman Center join YDCC.
January 9, 1968	NSP II approval received
June, 1968	HEW announces approval of 314(e) grant.
August 27, 1968	A. J. Henley appointed YDCC health administrator
January 25, 1969	Elections held for YDCC permanent board
July 21, 1969	Yeatman Health Center opens for business

*Adapted from Organization for Social and Technical Innovation, "St. Louis Corporation History," Report to OEO, June 30, 1969, pp. vi-viii.

CHAPTER VIII - ANALYSIS OF THE COMPARATIVE CASES: ANSWERS TO THE RESEARCH QUESTIONS

The pair of case studies on Denver's Eastside and the Yeatman District of St. Louis provides information upon which to base answers to the research questions described in Chapter IV. The answers presented below emerge from a comparison of two cases, and also, in some instances, from a look at aspects of one or the other cases individually. Because of the presence of important variables which could not be held constant in this comparison, the answers must be considered tentative at best. They are offered not in terms of verification and denial of hypotheses -- the questions were deliberately phrased as queries not as causal propositions, but as responses to those questions. The author makes no claim that the conclusions drawn represent complete answers to these questions, but the partial replies substantially cover the ground outlined in Chapter IV. The original questions are restated and conclusions from the two cases are organized under each.

The answers vary considerably in their coverage and adequacy. The case studies yielded a wealth of information on some of them, and interesting, but incomplete data on others. This result was inevitable given the large number of questions addressed by the cases. Those questions with the greater degree of confidence and on the basis of the most complete information are: (2) Causes of consumer demand for greater participation, (3) Main interests of health consumers and their support of innovations, (4) Provider-consumer conflicts over goals for participation and control, (7) Conflicts of consumer participation vs. those related to community control, and (8) Effects of different stages of program development and organizational forms. Partial answers are presented to the rest of the questions.

It must be emphasized that the conclusions of the comparison are in no way intended to judge the programs involved. Inevitably, however, they do involve some measure of evaluation in terms of providing answers to the questions raised, many of which are easily or subconsciously associated with the "goodness" or "badness" of a program. The central concern of this dissertation is to attempt to find out what has happened and to explain why. The results will in no way imply that one approach or the other was better. However, they will point out how the results differed and attempt to explain what caused these differences to occur.

The cases cannot be regarded as pure examples of the consumer participation or community control. They exemplify important aspects

of the models, but each has its own peculiarities as well. The Yeatman Center started with a considerably less militant population than did the three other HEW-sponsored community-controlled centers.

1. Inevitability of politics in neighborhood health programs.

> To what extent is the provision of neighborhood health care through federally-sponsored programs inevitably a highly political undertaking?

There is some evidence in both the Denver and St. Louis cases that the political entanglements of their neighborhood health centers are unavoidable given the federal requirements for consumer participation and substantial levels of demand being expressed by consumer representatives that the levels of participation and control be increased.

Administrators of the neighborhood health program in Denver have repeatedly expressed their wish that consumers "stay out of politics," and stick to qustions of health. Ironically, the providers have been highly effective political operatives themselves in their own dealings with federal agencies and, until recently, with local groups. They persist in trying to isolate the program from unfriendly political pressures although the success of the program to date derives in part from its consonance with political directions nationally and locally. DHH staff members who were reorganized out of their jobs

when the neighborhood health program was brought under the Manager's control, charged that the move was "politically motivated" in a negative sense. The recently elected militant Health Board views the program as thoroughly political in its foundations and impacts, and sees denials of this fact as attempts to exclude them from the political process.

The professionals most intimately involved in helping to establish the Yeatman Health Center and to assist the Health Committee which governs it were confident in, and explicit about, the assumption that their work was thoroughly political in nature. Political considerations weighed strongly in their balancing of alternative courses of action. Members of the Health Committee, on the other hand, were less politically oriented. Very few of them express the kind of power structure analysis which the more militant Denver consumer representatives endorse. As a group Yeatman consumer representatives were conflict-avoiding at the start, but they maintained a strong resolve and a real ability to recognize conflicts and to actually win some of them. They did not give their opponents the opportunities of open combat, but endured a series of hidden skirmishes.

The sets of interests operating in both cities insured a significant enough source of potential benefits to a variety of community groups and provider agencies and institutions to fuel a series of political controversies. The conflicts raged and sputtered as these interests clashed more and less violently at

different points in the growth of the programs. The histories of both programs are closely intertwined with the intensely political machinations of the local Community Action Programs and Model Cities programs.

In Denver the community action agency is the conduit or representation of consumers in the neighborhood health program. In St. Louis, the community action agency granted Yeatman, one of its target areas, more decentralized authority. This unit, no longer so integral a part of the Human Development Corporation, spun off the Health Center. The Yeatman Corporation Board of Directors, which retains ultimate authority over the Center, is not selected to relate to the community action agency and it is not beholden to it.

The neighborhood health centers developed separately from these more comprehensive and expansive vehicles for citizen participation, but their genetic make-up and their continuing relationships with their parent programs have linked their fortunes inextricably with thoses of the CAPs and Model Cities programs locally. The relationships of the health centers with these programs have been a fluid combination of competition and symbiosis. The neighborhood health programs provided one scene, or side show, in the continuing anti-poverty dramas in these cities. In addition, however, they were analogous to the rise of Off-Broadway. They developed into substantial, visible programs with strong local constituencies and national reputations. The parent organizations

eventually had to squint in the glare of this publicity and had to content themselves with complimentary tickets to the new main attractions. The programs which the CAPs "spun-off" were pulling the community action agencies into their own orbits.

2. Causes of consumer demand for greater participation.

> What causes consumers to demand greater participation in planning and running neighborhood health programs? To what extent is it concern over deficienciés in current health services and institutions? How important a cause is consumers' desire for personal or group power? How important a set of causes are individuals' motivations in comparison with organizational determinants?

Both dissatisfaction with present health programs and a desire for increased group power motivated Denver and Yeatman health consumer representatives to demand control over, rather than just participation in, decisions governing the neighborhood health program. The Denver consumer representatives are honestly disturbed by the shortcomings of the program as it was operating. In addition, they view the program as an effective and appropriate vehicle in developing for local neighborhoods a new level of control over the institutions which affect development and the lives of residents. The desire for group power is a stronger, more visible component of the demand for community control voiced by members of the Eastside Health Board, than was the case in the accomplishment of community control of the Yeatman Health Center.

It is hard to be horrified at the charge that the new Eastside Board is lead by power-hungry persons. Desire to acquire power is often viewed as a negative quality and the characterization voiced by providers in Denver was definitely intended as adverse comment. But how is the desire to acquire power logically different from the desire to hang on to power? Health consumer representatives in Denver would agree that they are interested in acquiring power, but tend to phrase the point differently. They want to take control away from the white power structure whose misuse of power has damaged the black community. For them, there does not even have to be evidence that this power was misused. The mere location of the power in Establishment hands outside the neighborhood is a raw sore. It is easy for professionals in all fields to view consumer demands for control as power-grabs, but it is at least as accurate to describe such moves as power-restoration or power-balancing activity.

The conflict between concern over the quality of services and the desire for power supports the proposition advanced by some that the provision of technically superior services _per se_ will be an effective substitute for community control, that provision of such services will diminish the demand for control. A related notion of substitutability holds that the generation of jobs for neighborhood residents will be an effective means of reducing consumer demands for participation. The Denver case provided a particularly appropriate context for raising these questions because the neighborhood health

program there is so technically impressive and the volume of paraprofessionals hired so large. The case denies the notion of complete substitution, but does not by any means prove that strong elements of substitution along these lines has not occurred. Members of the Eastside Health Board are more politically active and militant than the constituency which they represent. They are more politically aware and sophisticated, and are more firmly committed to the goals of increasing the political power of blacks and other minority groups. Given this set of interests, one would expect them to be relatively unaffected in their demand for control by demonstrations of the program's technical virtuosity. At the same time, consumers of the program's services, as distinguished from consumer representatives, may take less interest in the goal of increased group power precisely because the services represent a huge improvement over what they had before, because they are relatively well satisfied with the services now available. In a limited sense then, DHH administrators may be partially correct in their belief that the Health Board does not truly represent the Eastside community. This contention is misleading, however, if taken to mean (as its advocates intend) that the Board does not enjoy substantial support within the community in their drive for community control and endorsement of the acquisition of power as a primary motivation for that thrust.

These issues of potential trade-offs or substitutions were less susceptible to testing in the Yeatman case study because

the Health Committee and the YDCC Board enjoy control along with the provision of sound services and the addition of some jobs for District residents.

There were in Yeatman, however, some indications of the supposed substitution effect in employing area residents instead of placing them on policy boards. The form of this relationship in Yeatman may be a kind of corollary of the general proposition, i.e., that employing Health Committee members reduced the power of the Committee by (a) depriving the Committee of its younger, more sophisticated and vocal members, and (b) acquiring for the Center a set of paraprofessionals who were placed in roles and supervised in ways which encouraged them to carry out functions which the Committee might otherwise have had a greater share in handling.

Where both substantial employment of area residents and extensive involvement of residents on boards existed, there were interesting conflicts between the two. In the Yeatman Health Center, the younger half of the original Health Committee was hired by the Center, which pretty well decimated the Committee for a time. In Denver, a significant number of persons work for one health program or for another anti-poverty program and serve as consumer representatives for another. The multiplication of various anti-poverty projects with participation requirements and jobs for subprofessionals has fostered the development in both cities of a class of "professional participants" who play both provider and consumer roles, but with a fairly consistent orientation toward consumer objectives for participation. They will probably continue to straddle the fence until

they move into managerial positions which require both types of skills and talents, and which carry significant responsibilities and powers.

3. Main interests of health consumers and their support of innovations.

> What are the main interests of health consumer groups? What types of decisions and areas of policy concern them most? Does substantial consumer participation move a program towards more or less innovative health care?

Consumer representatives on the Eastside Health Board and the Yeatman Health Committee have expressed keenest interest in non-medical matters. They are more interested in aspects of the delivery of services than in the content of the services themselves, which they take for granted. The Eastside Health Board in each of the three stages of its development has focused its attention and spent most time on questions such as the condition of program physical facilities and the selection of staff members. Yeatman representatives were concerned about factors of convenience, such as the availability of transportation assistance, and determination of the hours that the Center would be open. These facts are consistent with the observation that a great many of the problems in delivering medical care are not medical in nature, but are essentially questions of social organization and human psychology.

The Denver Model City Health Committee carefully studied existing mental health agencies and operations. Their reports and

discussions evidence a heavy stress on style of delivery and location of services. Content of services was considered to be important, but more often than not, the services proposed depart from traditional views of mental health practice.

When the most recently appointed Eastside Health Board issued a set of complaints about the management of the Eastside Health Center, most of their points concerned housekeeping details and aspects of physical convenience -- dirty hallways, failure to send a set of appointment reminders, etc. Complaints about the staff had to do with their attitudes, not the services being rendered.

It must be emphasized that these "convenience" factors are by no means trivial. They have in the past constituted impassable barriers for poor persons needing health care. They remain significant determinants of the availability and acceptability of health care. In addition, convenience factors carry tremendous symbolic weight. Dirty halls image second class treatment.

A common fear on the part of health providers is that consumer representatives will meddle in purely medical affairs, that they will interfere with the efficient and professional delivery of health services. Consumers representatives in both cities did not meddle or interfere, except for rare and isolated instances. Some temptation existed for a couple of employees of the Yeatman Center who were former members of the Health Committee to exercise unauthorized supervisory roles in the functioning of the Centers. A harmless expression of this temptation was dealt with strongly by the YDCC Board of Directors and the problem was resolved.

Consumer representatives in both cities were found to be not opposed to innovations in the form of medical practice, but they were not particularly enthusiastic about them either. They did support innovations which were sold to them as examples of the best available in health care. Their primary interest in obtaining first-care health services and facilities did not conflict with providers' interest in trying out innovative approaches.

Even among the more militant consumers on the Eastside Board and the Health Committee, there persists a strong underlying conservatism about the quality of the services delivered and the content of those services. This particular trait was especially difficult for Denver Health providers to appreciate. On the other hand, the Health Board has not balked at innovative features of the medical care offered by the program. Departures from traditional medical practice include the use of teams of doctors, social workers and other professionals to treat patients and the employment of para-professionals in many capacities. In general, the Denver experience yields evidence that substantial consumer participation does not move a program towards less innovative health care. The high degree of consumer involvement is positively related to the great emphasis on training programs and the employment of local residents as staff members in the program.

The Yeatman Health Center opened for business using a major innovation in medical practice, the team approach to treating patients. This policy resulted in uneven work loads for the professional staff, so the actual practice has deviated somewhat from

the team treatment ideal. In going along with the team idea in the first place, the Health Committee endorsed an innovative approach. They have not balked at its modification, however, so they were not wedded to the notion of team treatment. The Health Committee gave strong support to other innovative policies such as the emphasis on preventive care and the inclusion of a sizable Social Services Department. The Committee sees this kind of innovation as essential if Yeatman residents are to learn new patterns of behavior in health care and to use the facility when they need to.

4. Provider-consumer conflicts over goals for participation and control.

> Do providers and consumers of health care at the neighborhood level hold the same goals for consumer participation? If not, in what ways do they differ?
>
> How do goals held by consumers and providers for consumer participation compare with those which their colleagues maintain for community control?
>
> Do providers and consumers perceive events in the development of a neighborhood health program similarly? Why or why not?

Providers and consumers held widely disparate goals for consumer participation. In St. Louis their differences were less pronounced because community control of the Center has blurred provider consumer distinctions, with many persons playing dual roles. The Denver Health Boards have a carefully drafted governing document which spells out clearly the

procedures for selecting members and the rules governing the functioning of these groups. However, this quite explicit and thorough charter masks crucial differences about the purposes of consumer participation and how best to organize it. There was some evidence found in Denver in support of the proposition that early agreement between consumers and providers about appropriate goals and functions for participation proved later to have been illusory, or that latent conflicts in this area surfaced later.[1]

Providers tended to stress positive functions to the programs themselves, and to society as a whole. They endorsed benefits accruing to individual participants, but only those of socio-therapy, good feelings and personal skills other than ones transferable to political activity. Providers readily articulated a variety of negative functions for consumer participation. These negative claims were argued consistently, but existed also as a grab bag from which counterarguments were drawn almost at random when the need arose.

These tendencies on the part of health providers are founded in their basic services orientation. This orientation applies not only to holding primarily services goals for the programs with which they are associated, but also for their individual professional lives. Providers believe that improvement of health care is the

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[1]See Michael Lipsky and Morris Lounds, Jr., "On Some Pathologies in Recent Social Planning Involving Citizen Participation: The Case of Health Services," paper prepared for the Symposium on Decision-Making and Control in Health Care, National Center for Health Services Research and Development, June 1970.

primary objective of the health centers. Some of the persons in Denver who ran the program from the division of Public Health before the reorganization, maintained service objectives for the program, but also emphasized the goal of acquisition of power by the consumer groups. In the early stages of consumer participation, consumer representatives accepted the service goal. Today members of the Eastside Board articulate the acquisition of power as a primary goal, but argue that this objective is a necessary step toward adequate health care. They recite inadequacies of the program as part of their case for assuming greater control over its operation.

The corollary of the service goal orientation is that consumer participation exists to further the improvement of services. The power acquisition orientation sees consumer participation more as an end in itself.

The administrators' behavior throughout the current Eastside Health Center controversy and during previous development of the program has been predicated on their professional perspective and strict service orientation. They are fully conscious of this outlook and firmly defend it. Excellence in the delivery of health care is of primary importance if the program is to have real impact in reducing poverty as well as assuaging the direct pains of ill health. The sharpness of the present conflict in Denver may be partly due to the very excellence with which DHH fulfills the service model and its objective of improved health care.

In contrast to the providers, consumer representatives stressed benefits accruing to the participating groups and communities. They also supported benefits to the programs themselves and to individual participants, but they were much more sanguine than providers about the more politically marketable of individual benefits. Consumers rejected the negative goals and functions attributed to participation and control although they conceded the presence of some difficulties and dangers. Both consumers and providers spoke in terms of benefits to society as a whole; however, consumers emphasized democratic ideals while providers stressed the significance of participation in providing for social order and control.

Militant consumer representatives in Denver are resentful of professionals, their concepts and trappings. They equate professionalism with impersonal modes of treatment, rigid enforcement of middle-class standards of conduct (strict interpretation of the Health Board Structure, for example) -- all a smoke screen for hanging on to ultimate operating authority. Their orientation includes an appreciation of the great importance of the quality and extent of services delivered, but focuses instead on the acquisition of <u>power</u>, the ability to control the institutions affecting their lives and immediate community.

A smaller group of professionals, many of them with medical backgrounds, seeks to shed what they regard as negative aspects of their professionalism -- its aloofness, the rigid and hierarchical structuring of working prerogatives. This group advocates the power model also. In Denver James Kent was the

staunchest advocate of this position. Other opponents of the take-over of the neighborhood health program by the central administration of the Department of Health and Hospitals concurred with his views to varying degrees. The group of professionals who helped to start the Yeatman Health Center are, to some extent, ideological confrères of Kent's. They were ultimately more successful in getting their mixed services-power position institutionalized. For them, service programs were important as vehicles for accomplishing broader social change and working toward a more equal distribution of power.

The negative motivations which advocates of consumer participation and supporters of community control attributed to each other accompany generally fair characterizations of the substance of these conflicting orientations, but failed to appreciate positively functional aspects of the other. Both shared a lack of understanding of what sustained the others' (and often even their own) role orientation. Denver professionals would readily accept the importance of poor persons acquiring dignity and self-respect, and gaining control over their lives -- but believed that the neighborhood health program was not the appropriate medium for accomplishing these objectives. In conceptual discussion, consumers did emphasize the value of technically sound medical care, but they saw no conflict between this objective and that of working through the neighborhood health program for greater community control.

The goals held by consumers and providers for consumer participation and for community control proved to be remarkably similar. In a sense, this is no surprise because the latter approach is an

extension of the former. The differences came in terms of how vociferously support for and opposition to greater control were expressed by consumers and providers, and by other institutions and agencies locally.

Consumers and providers demonstrated in both cases, but in Denver particularly, an extraordinary ability to perceive the same events in contradictory ways. A major determinant of this "Rashomon" effect are the professional backgrounds and interests of providers and consumers' antipathy to these orientations and values.

5. Tasks associated with different goals for and functions of participation.

> What tasks, responsibilities and prerogatives for consumer representatives are entailed by different goals for and functions of participation and control?

Consumer participation, as opposed to control, entailed tasks of responding to program proposals, screening applicants for paraprofessional jobs, publicizing the program and encouraging potential patients to use it. Community control, as exemplified by the Yeatman Health Center model, implied tasks of program policy-making. In practice, the difference was not so great. At Yeatman, the administrators of the Center were in fact firmly in control of the program by virtue of their greater expertise, full-time involvement with it and careful nurturing of personal relations with members of the Health Committee and the YDCC Board.

The tasks performed by consumer representatives in the two cases were basically similar. They emerged more from the practical problems of getting a program going and maintaining it, than they did from particular functions and objectives envisioned for and performed by consumer involvement or control. Both consumer groups played a strong role in helping to screen applicants for paraprofessional jobs. Both gave advice about the convenience factors discussed earlier.

In both cases, participation through employment in the program has been a significant source of jobs and income, and an important means of imbuing the programs with a greater consumers' perspective. Skills in community organization and political activity have been gained by consumer representatives in Denver and St. Louis as a result of their participation in health center affairs. Related to this point, the participation did contribute to the growth of black interest groups and helped them to gain access to public decision-making.

No evidence was gathered pro or con the proposition that participation increased neighborhood integration, strengthened mechanisms of social control or promoted neighborhood stability.

Participation has been heralded as a route to integration, control to greater segregation. These relationships are not apparent in the two cases studied. If anything, they are reversed. In Denver, participation coupled with a strong desire to control was associated with a breakdown of relationships between the

municipal health system and consumer representatives, although not to any visible malfunctioning of the health system itself. Community control, as expressed in Yeatman, was associated with cordial relationships between the Center and outside groups and institutions.

Consumer representatives in both places made valuable contributions to all phases of planning, although the process of their participation was expensive to individual participants and to providers in terms of time, energy and money. These contributions are recognized by both providers and consumers, who place greater emphasis on consumer contributions to earlier stages of development than to later ones. Consumers' roles in formulating program goals, in developing the plans themselves, and in early stages of implementation were more highly rated by both consumers and providers than were consumers' roles in later stages of implementation and program evaluation. This point applies more strongly to Denver because the Yeatman Center was still in its first year of operation at the time of this study. Nonetheless, the Yeatman Health Committee had already experienced a sharp drop in member interest and morale comparable in some ways to the absence of meaningful functions felt by members of the new Eastside Health Board.

The Yeatman consumers' group would have suffered an even more abrupt change of pace and roles except for the fact that the administration of the Center bent over backwards to consult them regularly on matters of considerable administrative detail. The Denver

experience illustrates the opposite end of this variable of managerial sensitivity to the changing functions of participation. The DHH administration failed to give the Board tasks and roles which would have promoted a sense of accomplishment and influence on the part of Board members.

Participation in both places approached democratic ideals, but Denver participants felt that these ideals were not being truly fulfilled. They referred to the ideals of democracy in their demands for greater control. In neither city was evidence found that participation left the consumers with feelings of bitter disappointment because their expectations were not met. This sense of frustration was perhaps being approached in Denver, but the consumer representatives maintained hope in their combative struggle for control.

A basic difference posited between participation and control is that participation undercuts the development of indigenous leaders and protest activities, while control fosters the growth of leaders and sustains protest organizations. The argument holds that participation integrates consumer representatives with the system which they were fighting against and inevitably forces an adjustment with that system, a diminishing of confrontation with it. This effect was not evident in Denver at any of the stages of evolution of approaches to participation. The Lay Advisory Board in Denver and the first Eastside Board composed of elected representatives included very few neighborhood leaders bent on confrontation, so their militancy could hardly have been watered down by their

participation. The few more politically active and change-oriented members of the first Eastside Board channeled these interests outside of the affairs of the neighborhood health program. The most recently elected Board, by eschewing the participation model, avoided any chance that they would get caught up in playing the Establishment game. Yeatman Health Committee members were a quiescent lot and like the first Denver groups had no activism to lose. Those members and former members with a stronger commitment to political changes have continued to pursue these objectives in health affairs related to the Center and beyond it, and through other channels such as Model Cities task forces.

The health centers did not stoke intra-neighborhood conflicts except for short-lived debates over the location of facilities. In Denver, however, the Eastside Center did spark competition between the black Eastside and the Mexican-American Westside, a conflict resolved somewhat when the Westside obtained its own neighborhood health center. Tensions between blacks and Mexican-Americans have been a continuing determinant of consumer-provider conflicts about participation in Denver. Neither group wants less than the other and both would like more. Their intermittent attempts at cooperation have failed by and large, but the two Health Boards did collaborate on devising a set of recommendations for redefining their authority.

In Denver, participation became such a hot issue that it may very well have decreased the amount of accomplishment made on

other goals and increased the time required to approach them.[2] But in both Yeatman and Denver, consumer involvement provided program administrators with a source of support useful in their dealings with other agencies and units of government. A good example of this effect was the cooperation between Denver Dept. of Health and Hospitals administrations and consumer representatives in pressing the federal government to permit a more liberal fees schedule to be used by the neighborhood health program.

6. Modes of influence available to consumers.

> What modes of influence are available to consumer groups? Are they necessarily restricted to the use of coercion in making their demands felt because they lack access to other modes of influence? How do consumer participation and community control differ on this point?

Consumer groups, in comparison to providers, had only the most marginal access to modes of influence other than coercion. In St. Louis, a major route to other modes of influence was provided by outside consultants who worked with the program in early stages of planning. Consumer groups in both cases tried consistently to use modes of influence other than coercion. They sought to acquire authority in addition to influence. The failure of Denver consumer

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[2]Looking at the Yeatman Corporation's activities as a whole, one is tempted to speculate that the Corporation's slowness to respond to opportunities and failures to garner funds for which they have applied in areas other than health may be linked to community control.

representatives to find and use other modes was due to their lack of resources, inadequate technical assistance and providers' tendency to work so as to restrict their access to other modes of influence: inducement, rational persuasion and authority.

In Denver, the consumers group tried to use other modes of influence -- rational persuasion, inducement and authority -- and have made extensive use of rational persuasion, although their attempts failed to attract professionals' recognition of this fact or to influence events their way. Indeed, the frustration of consumers' efforts at rational persuasion as a means of influencing the direction of the neighborhood health program was a primary reason why the Eastside Health Board resorted to more coercive tactics. The successful use of rational persuasion by the Denver Model Cities Health Committee during the planning year provided a sharp local contrast. Gordon's observation is borne out in Denver: "The sponsor's tactics appear irrelevant to the community and the community's tactics appear outrightly dangerous to the establishment."[3]

7. Conflicts of consumer participation vs. those related to community control.

> Does the existence of a substantial degree of consumer participation, but not consumer

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[3]Jeoffry B. Gordon, "The Politics of Community Medicine Projects: A Conflict Analysis," Medical Care, Vol. 7, No. 6 (Nov.-Dec. 1969), p. 425.

> control (in the context of firm local limits on the extent of participation), necessarily cause conflict about the proper methods and limits of participation?
>
> Does community control avoid some of these difficulties? How, or how not?

The program which encouraged participation, but refused to permit it to develop beyond a certain point, bought itself a prolonged and bitter conflict. The Yeatman Health Center, characterized by community control from the beginning, avoided a whole set of disputes, but was not without its own conflicts over consumer participation.

The Denver experience suggests that it is indeed the case that a substantial degree of consumer participation, but not consumer control, causes a great deal of conflict about the proper methods and limits of participation. The development of the neighborhood health program contrasts sharply with the Yeatman Health Center where these issues are avoided because a group of consumers has ultimate responsibility for the center's operation and survival. However, there do exist neighborhood health centers in other cities which have consumer advisory committees that are not demanding control. The general trend is for groups without control to move toward it; however, there are a few examples nationally of centers which have moved in the opposite direction.[4]

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[4]Gerald Sparer, George B. Dines, Daniel Smith, "Consumer Participation in O.E.O-Assisted Neighborhood Health Centers," November 13, 1969.

One might expect assumption of greater control by a consumer body to, in time, restore their faith in the institutions delivering health care and eventually to ease tensions between the groups involved. But when Denver health providers did make what they believed to be concessions to the consumers' position, it earned them little if any respite from consumer demands. Thus, the reassignment of Frank Justice from his job as Project Administrator at the Eastside Center, failed to assuage the Eastside Board.

Community control in Yeatman has meant a narrower range of disputes, especially those between providers and consumers. By helping to provide a more satisfactory set of continuing roles for consumer representatives (although still an unstable commodity) and by holding forth the prospect of easier transitions to future stages of development, community control worked further to reduce provider-consumer conflicts.

The St. Louis case was characterized by a bargaining style of politics based on a consensus orientation. In Denver, conflict replaced consensus and the program moved from bargaining to protest as the main form of provider-consumer interaction.

Community control does not in itself influence a program toward adoption of a consensus orientation and a bargaining style. The particular community and the personalities involved in Yeatman fed this atmosphere and method of operation. However, the fact of community control has contributed to the assumption of bargaining because it settled issues of the loci of authority, it helped to supply

some of the preconditions of bargaining, prerequisites which were lacking in Denver.

As James Q. Wilson has outlined them, the preconditions for bargaining include: the organizations involved must each have something the other wants and be ready to offer it; they must agree on fundamentals; the goal sought must be susceptible to bargaining, it must be divisible; there must be a high amount of continuing interaction among members of the different organizations; it helps to have a third party with a stake in the negotiations ready to help arrange it, to act as an intermediary; and there must be a wide distribution of bases of power.[5]

Community control in Yeatman helped to create something which other organizations wanted (a potential facility for training medical students and personnel, a possible association for outside agencies with a black community services program, etc.). It confirmed and reiterated agreement on fundamentals -- the rules were set, the lines drawn in a stable fashion. It widened the distribution of bases of power by creating a new one.

Conversely, the prerequisites of protest are: disagreement on rules or basic issues, indivisible goals or highly symbolic ones, power not widely distributed, low continuing interaction

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[5]James Q. Wilson, lecture to graduate course in Organizational Behavior and the Political Process, Harvard University Government Dept., March 26, 1969.

of organization members, no effective third party available to help.[6] These factors fit the Denver case quite well. A characteristic of the protest dynamic is that opposing representatives tend to view each other in terms of power and self-interest. The mutual accusations of base motivations voiced by Denver providers and consumers coincide with this observation.

In Denver the absence of an interested third party was sorely missed and reduced chances for negotiating a settlement between the Eastside Board and the DHH. The functions of such a party in enabling communications include permitting both sides to express their real terms secretly, being able to make side payments to one or both sides, and thereby discovering what the parties really want. This is often extremely difficult to accomplish once intense conflict has been reached and continues to be expressed.

8. Effects of different stages of program development and organizational forms.

> What effects does the process of moving through successive stages of development of a neighborhood health program have on provider-consumer conflicts over participation?
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> What variables of organizational and group structure influence the development and maintenance of conflict between health consumers and providers? How do these organizational determinants affect consumer-provider conflict?

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[6] Ibid.

What effects does moving through successive stages of development have on organizational variables?

The fact of progressing through successive stages of development of the neighborhood health programs was a major cause of provider-consumer conflict over participation. The different organizational requirements of successive stages of development shifted the set of tasks and responsibilities which consumers were needed to undertake and whose performance constituted meaningful participation. In addition, successive stages of development presented evolving demands on program administrators which led them to alter their conceptions of appropriate goals and functions of participation.

The largely internal conflict which surrounded the reorganization of the DHH in late 1968 is an excellent example of the effects of organizational maturation on conflicts about consumer participation, although the reorganization battle was between separate groups of providers -- rather than pitting providers against consumers. From an outside perspective it is easier for one to interpret the reorganization struggle as a natural, unavoidable transition in the evolution of a growing organization. Those persons with the imagination, initiative and drive to conceive and establish a new organization are seldom endowed with strength in administration and management. The tasks required to get such a program underway are qualitatively different from what it takes to keep it going. Of course, the vision of those who began the organization was for continued change and experiment, but the imperatives of organizational

maintenance and enhancement defy this dream. It takes rare detachment for the successful idealist to realize that his efforts will always fall short of what he would like to see emerge, that they will always get watered down in the end. The acceptance of change necessarily involves modification of the experimental demonstration as it becomes truly assimilated.

These factors hold true most strongly when the organization is growing rapidly. The problems of management, of establishing an effective routine of operation are less severe or apparent in the early days. The initial enthusiasm calls forth extra efforts from staff. Operating difficulties are unconsciously chalked up to the usual problems of getting underway. Organizations in all fields of endeavor experience this shift, often with substantial turnover of personnel. In any case, one expects the innovators to resist takeover by managers. They should fight ossification, just as one expects management-oriented second generation administrators to rush to impose rational organization on what they view as a floundering experiment.

Is the process one of ossification or of preserving and strengthening innovation by institutionalizing it? To innovators or agents of change, institutionalization always seems premature, rigid and repressive of the most important new aspects of the program. From the managers' perspective, timely institutionalization bails out good ideas whose very survival is threatened by inattention to the hard requirements of organizational survival.

This same view of organizational evolution can be applied to the Denver controversy over consumer control. The Eastside Health Board tried to change the established way of doing things. The administrative routine was lacking in some ways. The new emphasis on tight management, albeit via administration that is personal and by no means traditional, is itself a transitory phase in the evolution of the organization.

Both cases demonstrated that the set of functions to which a consumers' board or committee can meaningfully contribute, those tasks which give it purpose in the eyes of its members and their constituents, is constrained by the stage of development of the program. A board involved in the planning stages has before it a myriad of possible jobs to perform. Their help is needed to draft a satisfactory proposal, to satisfy federal requirements, to drum up neighborhood support, and to suggest ways of making the services acceptable to neighborhood residents. When the proposal is implemented, as the center opens and begins to operate successfully, the ready rewards of the initial period of involvement fade rapidly from memory. The earlier functions whose accomplishment brought kudos from all sides disappear as staff members who are sensitive and competent handle complaints, suggest improvements, and so forth. Dr. Cowen, head of the Denver Department of Health and Hospitals, assumed a set of functions which he felt were appropriate for consumer representatives to handle, but he failed to recognize the inevitability of change in the functioning of the Boards. Just as

the structure of the Board evolved through time, the functions of the Board had to develop. The consumers' demand for control, for a dramatic rewriting of the Health Board Structure, can be seen as a statement that the Board needed something more meaningful to do, as well as an expression of the requirements of Black Power. Cowen probably realized this, but he rejected the notion that this "something to do" was to take on a larger role in running the Eastside Center.

One almost gets the feeling from the Denver experience that particular success on the part of administrators in performing at the earlier stages of development may actually have made more difficult the handling of transitions to later stages. The administrators' competence at running the program made the original inputs of consumer representatives increasingly unnecessary. Perhaps the relatively long period during which DHH administrators worked smoothly with the consumer group locked the health providers into a rigid approach to consumer participation. They might have been more flexible if they were challenged more frequently en route. To some extent, the months of blissful collaboration between consumers and providers were prolonged artificially by the failure of the local community action agency to hold elections on time for the Neighborhood Action Councils from which members of the Health Boards are appointed. The most recent election was more than a year overdue according to the adopted procedures of Denver Opportunity, Inc. Administrative posture towards consumer representatives became habitual

and institutionalized, organizational arrangements became routine and hardened. The administrators enjoyed direct evidence from their relationships with consumer representatives that the group was fairly well satisfied. This may have made it harder for them to wake up to changing attitudes and conditions. When they did, it was like walking abruptly into a nightmare whose chaotic plot they felt powerless to direct.

The experiences of the Denver and St. Louis neighborhood health centers raise serious questions about the efficacy of continuing to use electoral mechanisms for the selection of consumer representatives. The means of selection most approved by the federal government and by local actors as well seeks to bestow legitimacy and to establish the representativeness of the consumer group. Langley Keyes and Lisa Peattie have argued with regard to the Boston Model Cities program that the process of electing the Model Cities Board actually worked to isolate the Board from its constituency and removed visible means of mobilizing resident interest and support for the program.[7]

In the cases studied, the community control model featured governance through a committee chaired by a member of the parent corporation's elected Board and peopled by a half dozen other elected Board members, plus all citizens of the District interested enough to volunteer. The consumer participation model functioned through

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[7]Langley Keyes and Lisa Peattie, "Citizen Participation in the Model Cities First Rows," paper prepared for seminar discussion of the Urban Ghetto Study Program, Laboratory for Environmental Studies, M.I.T., November 1969.

a Board composed of elected members of local Neighborhood Action Councils who are appointed to the job by the NAC chairman whom they have selected. In other words, the community control model combined election and self-appointment as a means of selection of representatives, the consumer participation model relied on election of representatives alone.

The Denver election procedures facilitate abrupt changes in the composition of the Eastside Board. There is a reasonable rationale for this strong a dose of democracy, for providing the opportunity for wholesale change, in the House of Representatives or a city council, but it seems inappropriate with regard to governing a service program like a neighborhood health program which requires a particular background and experience. For the most part, the second Eastside Health Board was experienced in community organization and anti-poverty politics, but poorly versed in questions of health care. The DHH officials can, with considerable justification, complain that they were saddled with a shifting community.

The Yeatman model of staggered terms and permitting an unlimited number of self-appointed members to serve on the Health Committee seems to be a more satisfactory approach. The Yeatman Committee members were in on the ground floor of that project. The members of the recently elected Board lacked experience with the health program and lacked personal attachments to it. This difference is, of course, related to the Denver program's longer existence, but it stems also from an exclusive reliance on elected representatives

who (theoretically) serve one-year terms.

For some reason, consumers have readily accepted the standards for electoral participation and style which are a direct carry-over from those of general elections. Consumer spokesmen, therefore, are periodically forced to make excuses for what providers and they themselves regard as poor turnouts, a paucity of candidates, and lackluster campaigns. The expectations for voter turnout are incredibly unrealistic. A fairer standard of comparison would be a low-interest, off-year primary in the inner city. Many central city precincts in those circumstances regularly record a voting participation rate of those registered of less than 20%, and the percentage of those eligible to register is lower still.

The distribution of authority and influence among relevant agencies and organizations sets the terms of conflict over participation and control. The structures of each agency and organization, their relationships with their constituencies and with other groups, determine organizational requirements for survival.

Consumer participation in neighborhood health programs is usually introduced "from above" because it is usually providers or provider organizations who take the initiative in organizing and establishing the centers.[8] This was clearly the case in Denver. In Yeatman, community control was introduced from above only in

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[8]George A. Goldberg, Frederick L. Trowbridge, and Robert C. Buxbaum, "Issues in the Development of Neighborhood Health Centers," Inquiry, Vol. 6, No. 1 (Mar. 1969), p. 37.

the sense that the National Service Program was an outside intervention. It emerged from below as well because local residents of the Yeatman area were actively involved in pushing for the institutionalized definition of community control in the establishment of the Yeatman District Community Corporation.

It is instructive to compare the Amended By-Laws and Articles of Incorporation of YDCC with the Denver Health Board Structure. The contrast symbolizes some of the basic differences between the two operations. The YDCC documents are simpler. They spell out the composition and powers of a single organization and its component parts. The language of these definitions of authority and rules is somewhat crude and awkward, but the organizational relationships and powers are clearly defined. The Denver Health Board Structure is a masterfully drafted document, so much so that the revisions of it which consumer representatives are proposing retain in fact many sections of the original. By necessity, the Denver Health Board Structure details the relationships among a few separate organizations. Therefore, the Health Board Structure is immensely more complicated.

The behavior of both providers and consumers is highly rational given the different constituencies to which they relate and whose continued support they require. The requirements of successfully catering to these separate constituencies result in provider and consumer behaviors which conflict. Key variables within individual organizations were the conditions of, and obstacles to, membership or employment, the rigidity of the hierarchy

of authority, and the distribution of responsibilities among component committees and/or personnel.

The professionals running the neighborhood health centers operated in a loosely knit constituency made up of peers and colleagues. Maintenance of their jobs and prospects for future advancement, plus growth of their professional status, required adherence to the service orientation rather than capitulation to a power model. Relinquishing control of the Denver neighborhood health program demanded of the administrators that they cease being their own bosses and begin to accept the direction of a consumer Board. In addition to the difficult personal adjustments involved, this switch would have knocked from under the professional administrators some important supports of their personal self-images.

Health consumer leaders were faced with much more continuously interactive relationships with their constituencies. Failure to relate effectively to their constituency is likely to have much more immediate consequences -- defeat in the next Action Council or YDCC Board election, for example. Doing a quiet job of attending Board meetings in Denver and contributing politely to the discussions is hardly an effective way of demonstrating one's commitment to better health for the district. In a situation where the voter turnout was 10% or less of those eligible, a consumer leader needs to make a splash. He needs to visibly confront the providers and to sustain a conflict situation with them.

He does not have control over favors or other currency with which to build and hold on to a group of supporters. In Yeatman, the chairman of the Health Committee, Mrs. Arabella Lawrence, sustains an alternate and highly effective route to leadership, and one geared particularly to the more moderate constituency which she represents. She relies on a close personal identification with the Center itself and her image as a woman of tremendous love and devotion. Her own life sustains this image, she does not need to reaffirm it in her behavior as leader of the Committee.

9. Formal structure vs. actual functioning of participation.

> Does the formal structure of consumer participation and control and the roles they imply coincide with the actual functioning of the participating group? If there is a sizable gap between formal structure and actual functioning, what difference does it make?

In both cases there has been considerable discrepancy between the stated purposes and mechanisms of consumer involvement and the ways in which participation has in fact proceeded. The gap between formal structure and actual functioning is in part an inevitable distance between the ideal and the realizable, but it also provides a range of discretion which invited conflicts about what are the desirable functions and limits of consumer participation. The gap is used by both providers and consumers as a source of evidence to support their claims of foul play and malfeasance directed at the other

side. It sustains a sort of Constitutional interpretation game which is periodically, but only temporarily, settled by revisions of the formal instruments which guide participation. Over time the gaps between formal and actual widened to the point where undertaking reforms and codifying ongoing revisions served to narrow the gap.

The history of the Denver program demonstrates the existence of substantial lead and lag time in the continuous adjustment between formal structure and actual functioning. The first consumer involvement mechanism, an advisory board, was asked to do more than its members were ready to provide in the way of planning assistance. However, the interest of consumer representatives picked up rapidly as the program got more firmly underway. The second stage of consumer participation, a formally constituted Board composed of members of the area Action Councils, performed many of the tasks outlined in the OEO Guidelines. The extent of the involvement of this second consumer group was consistent with the general tone of that document. The second Board sought to move well beyond this style of consumer participation and the restricted set of powers that accompany it.

Revisions of the YDCC By-Laws to date have consisted of changing such details as the age required for corporation membership, the definition of quorums at meetings, and procedures for filling vacancies on the Board of Directors. The amendments which Denver consumer representatives were pressing for focussed on the central question of who would control the program, providers or consumers?

10. Technical assistance.

> How important is the provision of technical assistance to consumer boards and committees in their development into effective decision-influencing and -making bodies? What is the operational significance of different approaches to rendering technical assistance to health consumer groups?

The provision of technical assistance to consumer representatives proved to be a critical ingredient in the development of their committees and councils. The Denver Department of Health and Hospitals' in-house approach to technical assistance, their relatively low commitment to and intermittent action on the subject contributed to the conflicts that program has suffered. The parallel experiences of the Denver Model Cities Health Committee and the Yeatman Health Committee with regard to technical assistance provide an instructive contrast. Both spent lengthy initial planning periods training consumers and fostering their development into effective representatives and committee members. By entrusting this function to persons unconnected with the eventual operating agency, and by sustaining a greater commitment to a continuing developmental or educational approach, Denver Model Cities and Yeatman equipped their consumer representatives better. This has not resulted in an absence of conflict, but can be credited with a major role in giving both programs the ability to provide useful and satisfying parts for consumers to play in the development of these programs.

Professionals working with consumer groups in both cities have experienced an extensive amount of "testing" from the representatives before they have been accepted with a degree of confidence and accorded some measure of trust. Testing appears to have been a more vigorous and prolonged activity in Denver; however, this conclusion is tenuous because a particularly sensitive and consumer-oriented group of professionals were involved in St. Louis, and Denver consumers seem to have a higher degree of overt hostility to representatives of the Establishment.

In Denver the common tension between the conflicting roles of federal agencies as sources of technical assistance and as program monitors was painfully obvious. The neighborhood health program sought and received some consumer training help from OEO, but this contribution was limited to isolated workshop retreats. On the one hand, OEO gave training to consumers and helped consumers and providers to discuss their differences. But on the other hand, OEO officials kept both groups hanging for weeks without returning decisions and by refusing to make judgments which would have helped to settle the disputes. OEO's attitude that the controversy over community control was a local affair not only served to deprive the combatants of third-party help in attempting to negotiate, but it also signified very clearly that OEO technical assistance did not extend to helping conflicting parties to resolve their differences and to learn from the experience.

11. Impacts of consumer participation and control on prospects for broader social change.

> Does the participation of consumers in planning and running a neighborhood health program isolate pressures for change of the broader health system or strengthen and focus them? How do consumer participation and community control differ with respect to this kind of impact? Does the development of consumer participation in these programs make them more universalist or more selectivist in their coverage and impact?

Consumer participation in both cases operates with a double-edged effect -- to diminish pressures for change of broader health systems and to increase the pressures for change on these same systems. In the short run, neighborhood-focused consumer participation and control channel impulses for change inward on that program. But at the same time, participation and control have worked to increase pressures on these same institutions by force of example, by competition for clients and patients, by restructuring the shape of demand for health services locally and by creating nascent interest groups countervalent to other health interest groups. Contrary to expectations, the evidence of both cases was that consumer participation made for more universalist rather than more selectivist coverage and impact of the program.

The Eastside Health Board channelled consumer impulses for change inward on the program of which they are a part. Therefore they focused pressures for change on the municipal Department of Health and Hospitals, relieving other local health institutions from the necessity of confronting consumer demands. Because the municipal

health department operates the Denver neighborhood health program, that Department has changed dramaticallly. What started as part of the functions of one Department has become a dominant part of the Department of Health and Hospitals' overall functioning in addition to running Denver General Hospital. In Yeatman, sponsorship of the Center by an organization wholly separate from the public health agency has meant that that agency has changed very little as the result of the Center's existence and governance of it by community control. It was probably harder for medical groups in St. Louis to oppose a black community corporation than it was for their Denver counterparts to oppose the Department of Health and Hospitals.

Michael Lipsky and Morris Lounds argue that hospitals' unresponsiveness may serve an important rationing function for those institutions, that it repulses actual and potential demand for services on the part of groups which they do not wish to serve, or from whom a greater demand would overload the hospitals' facilities.[9] If this rationing function holds true, it may be that opening neighborhood health centers or any sort of physically separate health care units serve a similar function of isolating the main operation from demands for changes. If an institutional outpost can accommodate new demands for services and for community control, it may protect the hospitals' and major medical agencies

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[9]Lipsky and Lounds, Jr., op. cit., p. 9.

and institutions' status quo for a while.

Hard evidence is difficult to come by on this question. In both Denver and St. Louis, the opening of neighborhood health centers was expected to alter the patterns of use of municipal hospital facilities. This type of impact has been a common claim and selling point by neighborhood centers' advocates. To date, the Denver and St. Louis programs have had difficulty documenting any change other than shifts in rates of increase in use. They argue that they are serving previously unmet needs and that therefore utilization of adjacent hospitals is not affected so much as it would be in the absence of the unmet need.

As a selectivist, as opposed to a universalist institution, the neighborhood health center may suffer inherent political vulnerabilities. There are periods during which public sympathy is aroused and programs mounted to improve services for the poor in some particular category. The selectivist orientation is politically feasible in some contexts and is guilt-relieving almost any time, but programs aimed solely at the poor are politically vulnerable in the long run. Lawrence Friedman describes how public support for public housing waned when the tenants of public housing shifted from working class whites to working and lower class blacks. The original objectives of providing work for the unemployed and housing for the unemployed were replaced by the function of providing housing for the elderly and blacks whose

need is perceived in different terms by the public at large.[10] James Q. Wilson has noted that social progress in this country tends to come in lumps or packages which include something for everyone.[11]

The continuing appeal of selectivist programs can be attributed in part to the visible nature of the approach, to its recognizable demonstration of concern for a particular group of persons who have suffered. The poor may not get better quality health care in a neighborhood health center, but the people of that neighborhood have been given a public facility. It is theirs. It represents something tangible they have wrung out of the Establishment, which for its part may be getting off cheaply in comparison to what universalist approaches would cost. There is much less political sex appeal in a system which subsidizes persons so that they can purchase their own medical care. But this condition is only true for some groups and may change over time, with disastrous effects for the consumers of selectivist services.

A danger inherent in the selectivist approach is that it builds up vested interests in dual systems. These interests

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[10]Laurence M. Friedman, Government and Slum Housing: a Century of Frustration (Chicago: Rand McNally, 1968).

[11]James Q. Wilson, "An Overview of Theories of Planned Change," in Robert Morris (ed.), Centrally Planned Change: Prospects and Concepts (New York: National Association of Social Workers, 1964), p. 21.

resist changes later on which would benefit the establishment of neighborhood health centers. There is no reason to doubt that these centers may not some day resist the location of private physicians in their neighborhoods if it becomes possible for doctors to do so in sufficient numbers to be competitive with the centers.

The universalist approach seeks to insure the poor equal treatment, equal access to services through being part of the same system. This approach has advantages in terms of the quality of service received or product consumed. The standards applied to a service are the same for everyone. The pressures exerted by middle class clients which insure adequate quality of services yield benefits to those who use the same system but have less political influence. Under a selectivist scheme, the pressures exerted by the low-income clients for better services are poorly supplemented by pressures from other sources. In order for pressure to be effective in a separate system, it is necessary for the users of that system to attract sympathetic response by persons outside of the system but with influence over it.

12. Demonstration effects of consumer participation.

> What is demonstrated by consumer participation efforts in neighborhood health programs which are "demonstration projects"? To whom and how does this process of demonstration occur?

Consumer participation in the St. Louis and Denver centers demonstrate convincingly both the great opportunities and

pitfalls of the concept. The cases demonstrate different things to different people. For instance, the Denver experience is read by some as validation of the providers' point of view, by others as evidence of its inherent fallacies. Due to the informal network of communications among neighborhood health providers and consumers in different cities, demonstrated knowledge traveled fast among those actively involved on both sides of the fence. Published accounts and federal reports and guidelines provided a slower, but powerful channel of demonstration. For consumer representatives in both Yeatman and Denver, the 1969 National Conference of Health Consumers in Berkeley, California, was a major source of news about what was going on elsewhere in the country and a forum for publicizing their own experiences.

Demonstration projects are a useful and proven vehicle for trying out new approaches, for getting a new approach the necessary political support to become operational. By its "demonstration" nature, a project may represent less of a threat to the established order or manner of doing things. In the absence of convincing evidence in support of a particular approach, the demonstration project offers a means to illustrate its effectiveness. A major problem with the demonstration project strategy is that it frequently confuses a variety of objectives. The content and style of these programs to date indicate that they are highly experimental. In theory and by logical definition, "demonstration" should mean taking a step toward transmitting knowledge that is already accepted, at least by the sponsors of the program.

With demonstration projects it is important to try to determine what aspects of them were most significant to their success. More often than not, the key determinants are factors -- policies, situational constraints, special qualities of top personnel -- which distinguish the operation from those which would develop if the approach were more basically implemented. The St. Louis and Denver experiences may demonstrate that the common elements in the given program category are perhaps not worthy of emulation, are not approaches and mechanisms which meet today's needs and move toward constructive improvements in health conditions. Of course, this has not denied these particular demonstrations the satisfaction of being heralded as successes based on the outstanding characteristics presented by their sponsors. Our willingness to accept these demonstrations derives partially from the national political and intellectual climate of the moment which seeks out and rewards innovation without applying much in the way of critical standards. A set of ideas packaged into a demonstration program is weighed and stamped "innovation" and takes on a dynamic of its own quite separate and insulated from its actual merits. Another part of the problem is that evaluation of these efforts is difficult, and in some ways impossible, where the benefits to be gained are of low visibility or take a long time before they are noticeable.

A key principle underlying the demonstration project concept is that an approach which is tried out yields visible results which

others may find worthwhile and seek to copy by applying the same approach. It presents visions of the agriculture extension agent's demonstration plot of corn grown with special hybrid seed or special fertilizer standing tall and proud beside the scrawnier control plot. The comparisons are just never so clear cut with alternative approaches to delivering social services. It may be that demonstration projects test potentiality, but do not really test the generalized feasibility of an approach.

To the extent that a program is adequately funded or perhaps given excessive support, a major point demonstrated may be that it takes massive amounts of effort, personnel, money and other resources to have the anticipated impact. It may be true that successful consumer participation in, or control over, a neighborhood health center requires an expenditure of resources that is unlikely to occur once the centers are no longer experimental. The conditions which fostered participation while they were demonstration projects -- timing of initiation, a dearth of alternative opportunities for participation, etc. -- may not exist later on.

The fact of being a demonstration project entails limited coverage. The program is by definition "a drop in the bucket." It claims to be no more: This was true in St. Louis, but not in Denver where the neighborhood health program covered most of the city's poverty population of 130,000. The status of being unique carries in Yeatman advantages and disadvantages which may obscure the value of the approach when translated to a more universal

application. For instance, the total costs to support a demonstration service or facility may include quite high unit costs. It is easier to overlook the dollar magnitudes when only a few of them are in operation. It is important to weigh the financial implications and requirements of the model if it will entail similar levels of support in the next generation. Will the next generation be similarly spoiled? Will a less generous childhood stunt their growth?

CHAPTER IX -- CONCLUSIONS

PRINCIPAL FINDINGS

The case studies yielded information which helps to define more clearly the nature of the demand for participation and control. The components of the demand were approached by searching for the motivations underlying the demand, the goals and functions for participation stressed by those making it, the main interests expressed by consumer representatives during the process of participation, and the tasks and activities which were part of the process. The demand was found to be not only an insistence upon better services and a larger share of authority over these programs, but also a set of assumptions about the activities and tasks which consumers anticipated that they would undertake, and expectations about the style as well as the substance of participation. The demand for control was both instrumental to the achievement of other objectives and an end in itself.

Questions of the possible substitutability of jobs for community control, or services quality and quantity for control turned out to be particularly interesting. The results were mixed, indicating some evidence of substitution, but demonstrating that complete substitution has definitely not taken place. The demand for participation and control is motivated by other concerns in addition to

questions of quality of services and of garnering jobs for participants and their neighbors. This conclusion underscores the realization that, while consumer participants are representing constituencies of consumers, they maintain objectives for participation which their constituencies feel much less strongly. Substantial consumer participation and community control were associated with consumer representatives whose primary interests were in the less purely medical features of the programs of the health centers. Consumers' focus on the non-medical aspects of the program parallels the experience of other consumer groups in neighborhood health programs. An early report on the experience of the Columbia Point consumer representatives concluded that they had "scrupulously avoided interfering with strictly medical questions."[1] Professional staff at the Montefiore neighborhood health center have found that patient complaints are directed more at the lack of physical comforts and at the way they are treated by professionals than at the quality of the care.[2] This conclusion indicates one reason why participation and control have not usually conflicted with spheres of authority and competence which professionals guard as their own. Health providers have traditionally

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[1]William F. Maloney, "The Tufts Comprehensive Community Health Action Program," Journal of the American Medical Association, Vol. 22, No. 5 (Oct. 30, 1967), p. 414.

[2]Harold B. Wise, Lowell S. Levin, and Roy T. Kurahara, "Community Development and Health Education: I. Community Organization as a Health Tactic," Millbank Memorial Fund Quarterly, Vol. 46, No. 3 (July 1968), Part 1, pp. 335-339 passim.

maintained a very expansive view of their areas of proper authority, part of which territory consumer representatives now occupy. Conflicts do exist between consumers and providers in the non-medical aspects of the neighborhood health centers, but the providers' fear that the quality of care would suffer from consumers' interference has proven to be largely unfounded.

It was striking to discover that, in both cases, consumer representatives made more important contributions in the planning stages of development than they did later during implementation of the projects. Community control seemed to provide the consumers with a somewhat more viable continuing set of functions and responsibilities, but consumer groups in both Denver and St. Louis experienced sharp drops in their members' activity, interest and sense of usefulness once the programs with which they were associated got fully underway.

The experience of the Yeatman Health Center cast doubt on many of the negative arguments about community control mentioned earlier. It counters the dominant arguments against control described by Alan Altshuler in his book Community Control.[3] In Yeatman, community control has not produced isolation or separatism of the District or of the Health Center. The center has not experienced particular problems with other groups or in its relations with outside agencies.

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[3]Alan Altshuler, Community Control: The Black Demand for Participation in Large American Cities (New York: Pegasus, 1970).

It has not moved the community toward racial separatism, intensified social friction, or been anti-libertarian. It has not conflicted with professional ideals of the quality of services, although it has modified criteria for selecting professional staff. It has not hamstrung any city-wide efforts to improve health conditions in low-income areas, except insofar as the city administration is not anxious to accord other districts the amount of local autonomy which Yeatman acquired.

The interpretation of the cases suggests that while the actors' ideologies of participation, the formal structures established to channel it, and the tasks and activities involved are closely linked, they maintain separate identities and lives as well. The interrelationships are imperfect. Each is, to some extent, influenced independently by conflicting sets of interests.

In delineating cause and effect, it was difficult to isolate influence attributable to a role as opposed to the particular personality filling the role. As Banfield has pointed out, people tend to be chosen for roles for which they are well qualified.[4] They remain in roles if they perform according to the requirements of the position. On the other hand, both the Yeatman and Denver programs have attracted unusually committed and able persons in the ranks of providers and consumers. Any demonstration program with such innovative features does attract this sort of

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[4] Edward C. Banfield, Political Influence (Glencoe, Ill.: Free Press, 1961).

talent. The administrative and consumer participant roles in a demonstration project are different from those of more routine operations. Nonetheless, it is difficult to deny the importance of the particular personalities involved. This conclusion is supported by other accounts of health projects which emphasize the skills of individual providers and consumer representatives.[5]

THEORETICAL IMPLICATIONS

The structuring and exercise of influence in the cases studied occurred along lines described by political scientists before. The cases did suggest that what occurred in both cities could be explained only partially as a redistribution of power. The new bases of influence and authority which were created by provisions for consumer involvement may be more properly conceived of as evidence of slack in the medical political system, or of unused and inefficiently used resources of influence.[6] The findings reinforced Miller and Rein's conclusion that citizen participation in community action programs has meant a transformation

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[5]Ralph Conant, The Politics of Community Health, Report of the Community Action Studies Project (Washington, D.C.: Public Affairs Press, 1968).

Elaine R. Savitsky, "The Politics of Neighborhood Health Centers. An Alternative to Mainstream Medical Care in Low-Income Communities," (Unpublished M.C.P. Thesis, Department of Urban Studies and Planning, M.I.T., June 1970).

[6]Robert A. Dahl, "The Analysis of Influence in Local Communities," in Bernard Frieden and Robert Morris (eds.), Urban Planning and Social Policy (New York: Basic Books, 1968), p. 234.

of the governing relationship as well as shifts in the location of power.[7]

The research findings substantiate prevalent elements of the theory of community organization. The factors which are said to impede community organization were important barriers in these cases. The cases studied suggested that variables of organizational structure and orientation and ideological positions of the actors were significant along with the situational constraints which are usually credited with the major share of causal responsibility.

The prerequisites of bargaining and protest styles of political conflict fit well the models of community control and consumer participation.[8] The conclusion that community control tended to narrow the range of conflicts about participation is explained by reference to this set of conditions. The experience of the two case studies suggests that community control helps to produce the preconditions of bargaining. In particular it contributes to agreement on fundamentals, to a wider distribution of bases of power, and to creation of a situation where the organizations involved each have something the other wants. Consumer participation was found to promote continuing disagreement on fundamentals,

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[7]S. M. Miller and Martin Rein, "Participation, Poverty, and Administration," Public Administration Review, Vol. 29, No. 1 (Jan./Feb. 1969), p. 24.

[8]James Q. Wilson, lecture to graduate course in Organizational Behavior and the Political Process, Harvard University Government Dept., March 26, 1969.

a narrower distribution of bases of power and a situation where one party did not have something the other wanted unless the first party created negative values through overt protests, which the second party wished to end.

The findings indicate that the set of values which are an important component of professionalism includes a strong orientation in favor of service programs. Professionalism includes more than just a set of values, a set of standards and a process for establishing them, procedures and training and socializing new members, and norms of collegial interaction. It includes also a strong element of being a repository of power and influence. It embodies self-interest and protects it in ways which make undeniable the interpretation that professionalism is in part the trappings of raw power.

The existence of the conflicts between alternative sources of legitimacy for social interventions noted by Rein between professional values, expertise and consumer preferences were demonstrated by the case studies.[9] In both cities, and in the neighborhood health centers nationally, the programs themselves and the behavior of many of the actors is premised on the conviction or hope that these sources of legitimacy can be happily mixed. They cannot. Attempts to use professional standards as a conceptual link between professional innovations and support for consumer participation were

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[9]Martin Rein, "Social Planning: The Search for Legitimacy," Social Policy: Issues and Choices (New York: Random House, 1970) pp. 193-217.

sometimes successful in the short run, but in the long run ran into conflict with other components of professionalism. There are conflicts inherent in the concept of professionalism, between the standards of practice which it espouses and the institutional imperatives of exclusiveness and retention of authority.

SUGGESTIONS FOR FURTHER RESEARCH

The study suggests a number of questions which should be given high priority in future research in this field. Primary emphasis should be placed on questions of "how to do it." The demand exists and can be expected to grow for some time. Continued pursuit of the approach is also justified by the substantial benefits to be gained through participation, although the costs involved can be considerable. Research which evaluates the effectiveness of alternative ways of handling participation and control should receive the highest priority from researchers. Questions in this category include such items as how best to give training and technical assistance to consumer groups. The case studies compared some broad alternatives, but more specific issues -- kinds of educational materials, etc. -- remain to be determined. Other unanswered questions of how to handle participation include: Which of the different methods for formally stating the responsibilities and authority of consumer representatives are best for different purposes? What changes in the process of applying for federal funds (and other monies, for that matter) would encourage more and better participation?

What kinds of shifts in program management, sponsorship, or whatever, would help to ease the transition from participation to control? How can consumer representatives be given a more meaningful continuing role in running a health program once the planning period is over, or does their usefulness necessarily diminish as implementation proceeds?

The growth of neighborhood health centers has occurred at a time when hospitals have been expanding their outpatient departments considerably in order to serve some of the same needs as those motivating the establishment of the neighborhood centers.[10] In 1969 OEO inaugurated a program of grants to hospitals for the refurbishing of their outpatient departments. Many in the health field argue that the large general hospital is destined to continue to be the center, and to grow in its capacity as center for all components of health care.[11] The question of whether to invest funds in networks of neighborhood health centers or in restructured outpatient departments is hardly an either-or proposition. The first case study of this dissertation examined a system in Denver where

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[10]Robert M. Hollister, "Neighborhood Health Centers vs. Hospital Outpatient Departments," in Planning for Health Services and Facilities and Its Relation to City and Regional Planning Activities (Cambridge, Mass.: Joint Center for Urban Studies of Harvard and M.I.T.), 1968, pp. V-1.

[11]E. Richard Weinerman, "Changing Patterns in Medical Care: Their Implications for Ambulatory Services," Hospitals, Vol. 19, No. 28 (Dec. 14, 1965), p.67.

there is comprehensive integration of neighborhood health centers with the municipal and other hospitals. But the two approaches are competitive for funds and public support, and for the energies of health improvement organizations and reformers.

> Which model is most appropriate today in various contexts? In the future which will be the most desirable? Some of the first OEO centers and similar programs under other auspices have been operating for some time and have enjoyed considerable and well-publicized success. Is this trend a relatively ephemeral fad tied to the fortunes of the anti-poverty program and will it lose favor as its parent institution continues to be cut back? Or does it represent a strong movement that will make permanent inroads forcing hospital out-patient departments to modify in its direction?[12]

The relative prospects for consumer participation which these two approaches present should be an important criterion to choosing between them.

Alternative proposals for reforming the delivery of health care should be evaluated for their implications for consumer involvement and control. To what extent is each congenial to consumer involvement? To what extent does each impede or facilitate eventual community control? What special problems or opportunities do they pose for participation? Health consumer representatives are currently taking part in deliberations in contexts quite different from the neighborhood health centers. These include hospital boards of directors and committees, free clinics, and the

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[12]Hollister, op. cit., pp. V-1.

boards of comprehensive health planning agencies. To what extent is participation at these different levels and in these contexts equivalent to or substitutable for the others? What problems and opportunities, what functions and dysfunctions, are associated with each? What is the difference between participation which relates to a health service without a physical facility located in the neighborhood and participation which relates to a service with a local physical presence?

How does participation and control in health compare with other functional areas and services? What specific mechanisms enjoy greater success in each? What different factors in the various types of services affect their differing congeniality to participation and control?

Some scant evidence was found in the cases that limited local opportunities for participation encouraged more extensive interest by residents in planning and establishing a neighborhood health center. It would be interesting to test the hypothesis that the level of the demand for community control of neighborhood health centers varies inversely with opportunities for participation in other types of services.

Another hypothesis which is suggested by the case materials and by accounts of other centers is that accomplishment of community control is easier when a service is crossing over from the private to the public sector, rather than remaining in either status. This question is very difficult to study intelligently,

but touches on the important broad issue of which services provide the most appropriate and most feasible contexts for community control.

It is imperative that more longitudinal studies be made on these questions. This is particularly true with regard to the community controlled neighborhood health centers, because many of the results on them are still not in. They have not existed long enough to answer some important questions about the effects of control, and the problems which they encounter as they mature.

We know relatively little about the process by which elements of participation in neighborhood health centers or its effects are assimilated by other health programs and institutions. The evidence on this point gathered by this study was sketchy at best. An important area of research would be to try to carefully trace this impact and to explain what determines the process of diffusion. It is relatively easy to identify instances of direct copying and adoption. It is extremely difficult to identify correctly and to explain instances of partial acceptance where the object of change does not exhibit the same forms or organizational arrangements as the stimulant of change. This latter area of impact may be particularly significant, but it tends to be overlooked in research and to be shortchanged in our evaluations of the effects of consumer involvement.

What significance does the size of a program and facility have on the prospects for participation? What influence does the scale of the immediate focus of consumer participation have as contrasted

with the scale of the larger program of which it is a part? The Yeatman Health Center and the Eastside Health Center are not too dissimilar in size, but the Eastside Center exists within a much larger program. It is important to learn the significance of this kind of variation. If participation flourishes in a microscopic environment and is stifled by association with a closely coordinated system or network of services, this fact could be immensely helpful in guiding policy decisions. Answering this question would require a fairly large sample of cases.

The few other instances of community control which exist should be studied intensively, although their sponsors and consumer representative groups consistently reject overtures from outside researchers. One cannot tell for sure whether or not Yeatman is a special case until its compatriots in control are similarly examined.

It is imperative that highly publicized, reputed instances of negative consequences of community control be studied. The Lincoln Hospital experience represents the most salient example of this category.[13] The accusations of harassment of professional staff by community representatives and other stories provide a convenient source of critical fodder for opponents of community control. There is a clear need for examination of these situations in ways which extend beyond the purely journalistic.

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[13]See New York Times, December 21, 1970, pp. 1 and 43; "Bronx Community Wants Control," Health/Pac Bulletin, September 1970, pp. 12-16.

A LOOK AHEAD

What are the future prospects for consumer participation and community control of neighborhood health centers? Are we helping consumer representatives to climb up the "ladder of citizen participation"? The metaphor brings to mind some vivid images ... perhaps we are adding new rungs in between the old ones, or knocking out some of the old ones and expecting the ladder to be just as easy to ascend. Maybe future trends will shake the ladder while they are trying to climb it.

We ask of the "professional participants" a variety of demanding roles. They are expected to be entertainers. Those among them who are forceful, talented speakers are singled out to perform as token consumers at conferences and professional meetings. 1969 and 1970 were the Years of the Consumer on the conference and banquet circuit. They make a good pitch and give their audience a chance to applaud ideas about which they are highly ambivalent. They are asked to serve as props, as symbols of participatory democracy at the same time that their attempts at influencing policy are thwarted. This is not to poke fun at the role. Those fulfilling it are accomplished and effective spokesmen for their cause. The danger is that listening to their speeches can become a substitute for hard action on their demands.

We expect consumer representatives to be sensitive interpreters of their people's needs, not merely to express them articulately but to identify areas of mutual self-interest and points of viable

compromise. The consumer participant differs from the consumer protester in that he is expected to straddle the fence more, to bridge the provider-consumer gap, to blur the distinction. His counterpart is the consumer-oriented professional or the health provider whose job it is to relate to the consumer group. The requirements of bargaining and negotiation inherent in both roles conflict at some point with the requisites of effective advocacy.

Neighborhood health centers are likely to experience continued pressures from consumer representatives for a transition from participation to control. They will meet less resistance as it becomes apparent that there may be little left to control in a short while, or when, for a variety of reasons, the health provider agencies are anxious to duck out anyway. In some cases, financial difficulties which threaten a center's survival may draw providers and consumers closer together over the common crisis and give consumers an important role in urging the government to provide new funds to sustain the centers.

Consumer representatives at different neighborhood health centers communicated informally with each other until the National Conference of Health Consumers was held October 2-4, 1969. The Conference provided a vehicle for a vastly expanded exchange of information, ideas and problems and resulted in the creation of a national organization of health consumers. For consumer representatives in both St. Louis and Denver, this Conference was a major source of news about what was going on elsewhere in the country:

what other consumer groups were allowed to do, what powers they had, what conflicts they encountered, how they were resolved or remained festering. Although the federal government was lukewarm to the idea of holding such a conference, both OEO and PHS eventually permitted centers they were sponsoring to pay the expenses of two consumer representatives. The objective of the Conference "was to create a national organization to represent the interests of health consumers" dedicated to working for community control of neighborhood health care.[14] A Steering Committee was formed at the Conference and charged with developing the new organization further. The conferees stressed the need for basic institutional change in the health care system. They spoke with great fervor about their demands. Problems of health care were causally linked with other sectors of society and the overall distribution of power in the country.

> There were many expressions of intense anger, bitter frustration, and total distrust. There was never the slightest suggestion that it might be possible for the government to comprehend the problems and take any constructive and effective steps toward their solution. There appeared to be general consensus that such a thing was impossible, at least so long as consumers do not have an independent source of strength to "keep them honest."[15]

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[14]William W. Chenault and Peter G. Nordlie, Memorandum to Dr. Alan E. Mayers, National Center for Health Services Research and Development, "National Conference of Health Consumers," October 9, 1969, p. 1

[15]*Ibid.*, p. 6.

Two observers at the Conference attempted afterwards to summarize the conferees' perception of determinants of maintenance of the health care system and the structuring of interests that define it:

> Equal health care is a right which is being denied poor people because the Establishment and the medical professionals are committed to perpetuating the status quo, wherein medical professionals get rich by treating poor people. Government programs seemingly aimed at helping to solve the problem are only placebos aimed at cooling the angry poor -- they are not seriously intended to solve the problem. They are, therefore, fitting objects of scorn, derision, distrust, and hatred.
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> Because the Government (Establishment, the Man) will not, on its own, move to solve the problem, the only option open to the poor is to take power into their own hands in order to bring about the necessary changes. The poor must unify and organize.[16]

The quest for power was related directly by the conferees to the problem of how to achieve better medical care. It was expressed as an instrumental goal, not as a goal in itself (although the goal of gaining power per se may have been there also).

The goals and demands expressed at the Conference are generalized beyond the individual case of the centers represented. They extend the demands of consumer representatives in their local situations by directing them at national bodies -- Congress, OEO, the AMA, etc. The local demands were translated to be expressed at this broader audience. As such, they constitute a more comprehensive and complete picture of the implications of local consumer

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[16] Ibid., p. 9.

demands and provider-consumer conflicts for broader social change of the same sets of institutions, and other local and national bodies.

The future of consumer participation in neighborhood health programs consists not only of residents' involvement in those particular institutions, but also of the impact of these instances and periods of participation on the policies of other health agencies and the arrangements for participation which they adopt. In a sense, then, the future prospects of consumer participation in health will be determined by the success of the neighborhood health centers as demonstration projects.

The conflicts between the centers and local medical associations and groups of pharmacists, etc., are significant beyond the purely local fight and the local implications for a program. They are happening all over the country and are skirmishes in larger battles for change within the system. The demonstration effect operates in part through the public awareness created by these separate conflicts. The publicity accorded conflicts and the involvement of a broad range of individual participants brings some of these notions into good currency. The emergence and existence of centers is central, but their existence lends framework and substance to the winds of change which touch areas with no connection at all to neighborhood facilities.

It is too soon to tell whether or not the demands for community control of neighborhood health centers across the country

will strengthen or weaken the chances for lasting improvements in our health care systems. It may be argued, as Moynihan did with regard to the CAPS and poverty, that emphasizing consumer participation ultimately obstructs the upgrading of health services because it undermines the political support necessary to sustain these changes.[17] To date there is very little evidence that such an effect is occurring in the area of health, and there are scattered instances of consumer representatives in neighborhood health centers pulling together with health reformers nationally in urging the implementation of system-wide changes.

The ideals for participation expressed in the federal guidelines can be expected to diffuse throughout the medical profession. The fact of neighborhood health centers attempting to meet new standards influences the standards employed by other institutions in the health field. The guidelines read like a list of requirements to those running a neighborhood program. To the physician operating outside of such programs they read more as a manifesto. With time, although they will no longer be read, they would read like an elaboration of established, accepted professional procedure.

The problem of maintaining financial support is especially critical to the issue of how consumer participation in neighborhood health centers changes. In order to survive, thr projects have to

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[17]Daniel P. Moynihan, Maximum Feasible Misunderstanding: Community Action in the War on Poverty, (New York: The Free Press, 1969.)

find sources of funds other than those which got them going. Their demonstrated effectiveness is supposed to help them accomplish this task. These financial requirements take a great deal of the time of project directors. In addition, they deflect the scope and substance of their projects in directions which will help to attract money. Neighborhood health centers will get an increasing portion of their budgets from Medicare and Medicaid, but this will not be enough. They are attempting to piece together grants for categorical programs under existing legislation. Imaginative and forceful grantsmen can accomplish this and continue to run a basically unitary service, but the process pressures the Centers toward developing into the sort of clinics which they sought to replace -- those directed at specific age groups and particular categories of disease.

The longer range prospects for consumer participation and community in health are difficult to assess. A variety of trends relate to this future and they are difficult to project with much confidence. Too many "if's" are involved. If public transportation systems continue their downslide, the problem of accessibility of health services for the poor will continue to be severe. If residential segregation maintains its current level or increases, the concentration of the medically indigent will justify the location of additional special facilities in those areas. There are a myriad of factors in the future organization of medical care which could affect the prospects of the centers and of consumer participation

in them: the rate at which costs rise, the continuing trend toward group practice, the structure and coverage of federally-financed health insurance, changing patterns of disease, and so forth.

Herbert Kaufman predicts that the current, cyclical peaking of decentralization will result in disparities of practice which will create greater demands for central intervention to restore equality. This task will be approached through a resurgence of natural competence, by taking administration out of politics and politics out of administration.[18]

As the conditions which motivated the creation of neighborhood health centers are improved -- partly through the establishment of the centers themselves, partly in reaction to them -- there may be less of an impetus toward participation or control as instrumental goals. If the demand for participation is satisfied through a variety of other reforms, the demand may have weakened and health care may be a less inviting context for expressing it. On the other hand, if improvement of health conditions does not keep pace with rising public expectations and the general demand for greater political participation by black and low-income people remains unmet, health institutions can expect to have to contend with it for a long time to come.

APPENDIX A: METHODOLOGY

STUDY PROCEDURES

The case studies were researched through extensive use of relevant documents and open-ended interviews. The study procedure wove together these sources, seeking to blend the skills of the journalist and the historian with those of the social scientist. By immersing myself in a wealth of primary material, I practised a sort of "purposeful wading through" in digesting and assimilating the material. In the paragraphs which follow I describe in some detail the essentials of this approach.

I entered both Denver and St. Louis under the auspices of the agencies in charge of the neighborhood health programs which I was studying. In St. Louis, the Yeatman Health Center allowed us to study their operation and helped to arrange interviews with persons in the area whom we wished to see. Mrs. Geraldine Binion of the Center staff was immensely helpful in this regard. Our initial contact in Denver was through the local Model Cities Agency. We approached personnel of the Department of Health and Hospitals through Mr. Paul Poitreus, Model Cities staff person responsible for health planning. It is important to note this route of entrée, because many neighborhood health programs, Denver

included, have had their fill of outside researchers and as a rule deny permission to study their programs. Consumer councils are particularly sensitive to this. Nonetheless, DHH staff and all other persons whom we interviewed were very generous with their time and cooperative in helping us to accomplish our study.

A basic fact of our approach was that it came through the cooperating agencies, not through the consumer groups. The distinction is blurred and less important in St. Louis, but in Denver our Establishment-tainted presence undoubtedly had some effect on how we were received by consumer representatives and their colleagues. Our primary research, however, was limited almost entirely to program administrators and related professional personnel. On the other hand, interview records made available to me by the Tufts study project wholly confirmed our findings there and included many more interviews with consumer representatives.[1]

INTERVIEWS

Decisions as to whom we should interview in each city were based upon preliminary reviews of the documents available and upon suggestions from persons whom we were interviewing. I attempted to interview the key actors in each case and came close in both cases

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[1]Public Health Service-sponsored study of consumer participation in neighborhood health centers, by the Dept. of Social Community Medicine, Tufts University School of Medicine, Peter New and Seymour Bellin, principal investigators.

to completely covering this category of persons. Sometimes, in the interests of time, we talked only to a few representative persons from a group who had acted in concert or who played similar roles in the cases. Thus, we spoke with several, but not all, of the members of the group of eleven Department of Health and Hospitals employees who opposed reorganization of the Department. Our selectivity was even greater with regard to the consumer representatives themselves.

I conducted most of the interviews together with Mrs. May Hipshman, Research Associate, M.I.T. Department of Urban Studies and Planning. We opened each interview done together with a brief description of our purposes and an outline of the types of information we expected to acquire from the interviewee. This introduction was usually handled by Mrs. Hipshman. A typical, composite one went as follows:

> We are looking at various innovative neighborhood health programs across the country in order to develop curricular materials for a course in health planning at M.I.T. Department of Urban Studies and Planning. I am a Research Associate at the Department. Mr. Hollister is a Ph.D. Student doing a thesis on the consumer participation aspects of these programs. We are particularly interested in learning from you...

The pitch varied with the individual whom we were addressing only in terms of the description of what we hoped to learn from the interviewee.

We approached each interview with a set of topics to be covered. This agenda of topics served as a guide to insure that the

interviews covered the questions we had in mind. In some cases, where we expected some resistance to the line of questioning or otherwise felt it to be important, we determined an order for the first few questions. We took notes as we felt we needed to in order to provide a full record of the interviews. In general, the person less actively engaged in questioning at any point in the interview took more copious notes. This technique of dual interviewing seemed to work well because it allowed at least one of us to be looking at the interviewee throughout the interview, avoiding the interruptions of face-to-face contact often inevitable in solo interviews which require careful recording. In addition, the presence of two interviewers provided the interviewee with a larger audience. He could choose, to a certain extent, the interviewer to whom he wished to relate most directly. Clear expressions of such interviewee preference were rare; however, we felt that in a couple of instances this did seem to help.

The wording of questions and the conduct of the interviews in general were facilitated considerably by the fact that all the informants were knowledgeable about the situation under study. The interpretation of questions and responses occurred in a context of a shared background of quite specific experiences. This is not to claim that differences in the use of words were absent, but only to state that some of the usual obstacles to accurate communication between researcher and subject and to comparison of information received from different sources were absent by virtue of the intense

personal involvement of the interviewees in the circumstances being examined. Differences among respondents in the meanings of different words or the facts surrounding a particular development became clear in the process of questioning because there was ample opportunity for follow-up questions and other probing.

A particular difficulty of free-answer surveying is that of controlling for differences in interviewer effects.[2] This problem was side-stepped by conducting interviews with the same two interviewers.

In accordance with accepted theory of interviewing procedure, the questioning proceeded from the general to the specific.[3] The interviews made extensive use of questions about individual roles in actual events. We always asked for their explanations of why things happened as they did, and for their suggestions and visions of the program's future. We queried them on how they thought persons on the other side of questions viewed the situation.

The questions were of the free-answer variety, but were in a practical sense much more directive than many free-answer interviews because of the interviewees' common connections to a particular situation and set of experiences. The free-answer technique gave the interviewees a degree of latitude in responding

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[2]Stanley Payne, The Art of Asking Questions (Princeton: Princeton University Press, 1951), p. 51

[3]Ibid., p. 34.

which they would insist upon precisely because of their closeness to the situations. They tended to perceive the development of the programs as extremely complicated although they attributed quite simple motives and patterns of behavior to their adversaries. This conviction of complexity and their own experiences with the intricacies of conflicts surrounding the programs make for considerable hostility to questioning of the closed category or tightly structured variety.

The interviewees varied in their intimacy with the different aspects of program histories being examined, their position with regard to the program, and their educational background and style of expression. The respondents varied from the extremely garrulous to the painfully reticent. Some interviews with persons closely connected with a program and given to analytical perspective about it verged on monologue. Very little probing or direction were necessary because they structured the interviews very much as we would have. Several interviews in each city took this course. Other interviews required substantial prodding and a steady stream of direct questions. A substantial amount of evidence was gathered from the form of respondents' replies. The open-ended nature of the interviews allowed respondents to emphasize those aspects of a situation which they chose to focus upon and to indicate which subjects they felt most comfortable discussing at length.

In conversation with interviewees, where expression of my own views was called for, I tried to be candid. However, there

is an advantage to be gained in unstructured interviewing by agreeing with whatever the interviewee has just said. This sometimes encourages him to elaborate further. At other times, challenging their views or undertaking more critical questioning can have a similar result. I tried to encourage interviewees to state their opinions and points of view as fully and openly as possible by alternating between these two modes of questioning as seemed most productive depending on the progress of the interview and the kind of person with whom we were talking.

We were able to talk more than once with some of the persons interviewed. The content and feeling of these second interviews convinced me that the first ones are inevitably limited. Doing a case study through a series of one-shot interviews has certain advantages in terms of the freshness brought to the situation being analyzed. It was useful to talk to the actors over a period of a few days so that comparisons of their stories and attitudes were not blurred by the passage of time. On the other hand, people tend to behave differently once they feel comfortable with you. Their stories change somewhat. I missed any increments of knowledge which might have derived from a lengthier stay in either city and the consequent opportunity for repeated contact with the actors involved. Hopefully, this difficulty was taken care of by the fact that my snapshot images were amply supplemented by documents and other written records.

Mrs. Hipshman and I wrote up the interviews separately without consulting each other except in terms of general impressions

and with regard to specific factual information relevant to the conduct of subsequent interviews. We reviewed notes individually at night, in order to fill in any gaps. Occasionally we gathered information in settings where taking notes would have been inappropriate or counterproductive. For instance, in St. Louis we met for two hours with an informant after a meeting of the Health Committee and were joined later by a project administrator. The tone of communication was informal and friendly. Notetaking would have created a stiff atmosphere detrimental to learning as much as we did by leaving our notebooks outside. In cases such as this one, we wrote notes as soon as possible following the interview. We did not appear to lose much information through this procedure since the content of our records corresponded well with those of interviews where note-taking was done on the spot. There was, however, a considerable effect on the recorded sequence of the material collected.

The interviews were written up as closely to verbatim as possible. A serious attempt was made to include in the notes the precise phrasing of answers to particularly important questions. This was impossible in any strict sense. I learned that in attempting to record verbatim, the best possible approach was to use notes which approached the verbatim in inclusiveness and to use these as the basis of a reconstruction of the interview itself. This method of filling in blanks and elaborating on the notes worked well as judged from comparison of the interview

records compiled by the two interviewers. The technique of reconstruction was easiest when I liked the interviewee immediately and when we were similar in background and professional perspective. I made a serious effort to control personal likes and dislikes, but these obviously have an influence on capability to reconstruct interviews accurately. The process of reconstruction was most difficult when the interviewee was different from myself in his style of expression or attitudes.

The recorded, reconstructed interviews tend to capsulize and to rationalize the interviews. I was forced to this conclusion by comparing the interview records I prepared with interviews of comparable staff persons and consumers conducted by staff of the Department of Social and Community Medicine of the Tufts School of Medicine in their research project on consumer participation in neighborhood health centers. The transcriptions of their recorded interviews are longer, and include a great deal of repetition. It is often difficult to understand the conversation in these interviews because they include incomplete sentences and what are non-sequiturs to anyone who was not there. Reconstructed interviews or modified transcription interviews, therefore, are unconsciously edited both for repetition and general coherence. The process of remembering what an interviewee said imposes a structure, a logic and connection with the questions asked which goes beyond the words actually spoken. Hopefully, it does not isolate the sense of those words. I have been conscious of these problems and believe

that the potentially negative effects of the interviewing and recording techniques used were effectively minimized. The benefits far outweigh the problems which would have been incurred by using tape recording equipment. By exchanging my records of interviews in Denver with interviews of many of the same individuals which were conducted two months later by the Tufts project staff, I was able to check the reliability of my information. The comparison indicated that our results from our different sets of interviews were very close. I gained some additional data as well as this invaluable check on my research procedures and findings.

The process of recording the interviews from my notes was immensely satisfying as well as frustrating. The notes recalled personal mannerisms of informants and parts of interviews which were poignant or amusing at the time. The interviews tended to come back quite vividly. The joy in working with them which I experienced is probably not surprising because the substance of the topic bears on the lives of people and the involvement of an unusually interesting and deeply committed collection of persons. Many of their statements made deep impressions on me regardless of how I identified with their general views and actions in the particular situation being studied. The reflections brought about by reviewing the notes evoked considerable pleasure. On the other hand, it was hard with words alone to convey precisely what the interviewees had said. I adhered as strictly as possible to a rule of recording the words spoken, rather than the thoughts and sentiments conveyed.

The two often do not jibe completely. I found myself continually fighting an impulse to write in stage directions to accompany the interaction which I was transcribing-reconstructing. The basis of this temptation was the recognition that a great deal of what is communicated between interviewer and interviewee, especially in a case study context where a level of prior knowledge of the events discussed is assumed on the part of both parties, is done through nonverbal shorthand and through shortcuts and signalled assumptions. Many of these shortcuts and assumptions are apparent from a reading of the interview records, but many are not. There can be considerable discrepancy between the printed word and the word spoken by a face and body which are seen first hand. The information lost in translation is not of a magnitude which would distort the direction or even the general level of feeling of an individual respondent, but the issues of consumer participation being dealt with here are complex questions. The personal motivations and structural constraints are extremely complicated. Therefore, the interview records cannot be sufficient in themselves. They are a disciplining factor as well as a fund of raw or semi-digested material with which to build the case studies. But in another sense they are valuable as a stimulus to recollection of the analytical framework developed by the interviewer in his talks with local actors and his perusal of relevant documents.

OTHER MATERIALS

In both cities I made extensive use of documents relating to the programs: applications for funds, interim reports, minutes of meetings of the consumer bodies, newspaper accounts, and so forth. The documents provided a check on information obtained through the interviews. In addition, they were a rich source of primary factual material. On questions of personal attitudes and the dynamics of conflict, the printed materials tended, as one would expect, to be circumspect or to avoid subjects.

Documents intended for public consumption and even internal staff papers tend to avoid explicit treatment of conflicts and to employ a sort of obscuring shorthand in reference to them. The interviews enabled a more educated reading between the lines of these sources. Material from documents and interviews was integrated first while I mined each of these sources and later when I was constructing a record of local events and developing these into a coherent case. Each source went a long ways toward making up for the limitations of the other. Documents often are less than candid, yet provide firm benchmarks for chronology and explicit agreements in detail. People are short on facts when they talk, but display attitudes and reveal personal roles more frankly.

GENERALIZATION FROM THE FINDINGS

There are clear limits to generalizing from evidence of a pair of case studies. But the limits which are so widely assumed may be

overstated. I would argue that the Denver and Yeatman cases have considerable relevance to other programs, especially to those under similar federal sponsorship. Both represent clear instances of the models in question. The organizational variables and stages of development which they evidence are particularly strong and forcefully demonstrated in fact. The experience of other programs shows that the histories of Denver and St. Louis are parallel to theirs in many ways. Moreover, one can match aspects of situation and organizational setting which hold true in both of these cities that correspond closely to those found elsewhere. It is unlikely that anything which approaches complete parallelism can be discovered, and it might be argued that this lack is a profound limitation to generalization because the variables operate in clusters -- the isolation of a couple of specific variables may be a mistake therefore.

The same difficulties encountered in attempting to control for differences among these programs must be interpreted as barriers to the automatic or easy generalization of the findings of this dissertation to other programs in other cities. However, generalizations of this type should in any case be of the nature of application or translation of others' experience, rather than unthinking imposition of these findings.

APPENDIX B: DISTINGUISHING BETWEEN CITIZEN PARTICIPATION AND CONSUMER PARTICIPATION

The traditional term used in this area of inquiry is "citizen participation." This dissertation concerns itself with basically the same area of interest but focuses on "consumer participation." What is the difference? Why shift to a different label? Doesn't this merely compound the semantic difficulties just mentioned? I use the term "consumer participation" because it is a useful way to distinguish a particular set of activities, structures and types of participants from those implied by the more inclusive concept of citizen participation. The concept of citizen participation has taken on global dimensions -- it is applied to everything under the sun, from involvement in electoral politics, to membership in voluntary associations, from taking part in anti-poverty programs to providing residents of low-income areas with a measure of self-government. The term has been stretched to such broadly inclusive usage because persons with widely divergent objectives find it a useful label in contrasting settings. The term has acquired a certain amount of recognition value and legitimacy. Government programs require some measure of citizen participation. Participation itself is an even more basic root dilemma of the age in which we live. We are bombarded with Sunday supplement articles on

alienation, and as a people, we share feelings of social disengagement. We feel common urges to participate, to be involved, to contribute in meaningful ways to what is going on, to have a share of control over our everyday lives and our destinies. In reference to government programs, competing interest groups and points of view do battle over the appropriate operational interpretation of the concept. As these different interpretations evolve and are elaborated into ideologies or attach themselves firmly to ideological stances and to recognized administrative approaches to the concept and its attendant problems, the umbrella of the term widens to the point that it leaks badly.

We accommodate the conflicts linguistically by permitting the term to house dissident tenants. However, as these conflicts sharpen or their opposing characters become better realized and accepted, it is becoming increasingly difficult for persons to use it in contradictory fashion. The conflicts and distinctions come to be expressed through new words and phrases. It is increasingly true that observers and activists distinguish between citizen participation and local control. This conflict results in defining more clearly the limits of each conceptual label. Hopefully this dissertation has contributed some to mending the old umbrella of citizen participation. Exactly where usage of the term and its attendant concepts will settle with some stability is an open question.

The fluid and poorly understood distinction between citizen participation and consumer participation, the basic lack of

agreement about the distinction or refusal to admit the usefulness of such a distinction, provides actors in public programs with freedom of movement with respect to the concepts. While not conceiving of their behavior in these terms, neighborhood health program administrators (and other anti-poverty program professionals), in some circumstances, find it to their advantages to declare and to widen the cleavage between the two -- citizen and consumer. This is what an administrator is engaged in doing when he wishes out loud that consumer representatives with whom he must deal were more representative of the actual patient population of his program. He may maintain that the citizen's policy board is packed with citizens whose poverty credentials may be in good order, but who are not consumers of the program, or who represent broader citizen interests rather than consumer interests. When an administrator, for example, desires that a consumer health board devote itself more exclusively to health issues and avoid "politics" or issues of political power, when he accuses them of being motivated by lust for power rather than concern for quality of medical care, he seeks to distinguish between citizen -- the broader term -- and consumer. He wants to treat these representatives and their constituencies in their roles as consumers rather than in their broader roles as citizens. It is not surprising, of course, that his consumers, who are also citizens, prefer to act as though they are citizens who are also consumers.

My use of the term "consumer participation" is a choice among existing, prevalent terms. Consumer participation is the phrase

in vogue, the one commonly applied to citizen participation in the planning of health services and facilities. Therefore, it is natural to use it in this dissertation. But there are a number of other possible causes for the shift in usage and meanings which underlie the increasing popularity of "consumer participation." I offer several below.

This exercise in searching for reasons behind the emergence of a new label is a way of exploring the conceptual differences between consumer participation and citizen participation. The exploration leads to sources of proof for the existence of definable differences and provides a basis for delimiting more clearly the meanings of both. This pseudo-linguistic analysis is not intended to imply direct causation in each case. The approach is largely speculative although clearly some causal connections are there.

1. CONSUMERS CONSUME

"Consumer" implies more a narrow interest. Consumers are people served by a program, people who partake of an identifiable service or physical offering. One can be a citizen participant in an activity, such as planning for a program or a policy, but to be a "consumer" requires that the program or policy in question yield something which the participant can directly enjoy. The focus on "consumer" rather than "citizen" suggests in part the realization that citizen participation has been a guise under

which citizens, citizens concerned, but not of the groups and individuals served, have participated. The experience with health councils of neighborhood health centers to date has been that the status of consumer for these purposes has not been strictly defined or enforced. However, the intent and implication are clear. The distinction between being poor and working with or representing the poor (social workers, other agency staff, etc.) has been made explicit.

It is more appropriate to talk of citizen participation in urban renewal because, although physical development is accomplished as a result of the process, the basic products -- housing and community facilities -- are not items that we think of consuming although we need, use and enjoy them. The focus on "consumer" makes more sense then in references to categorical programs as opposed to ones which are more broadly cast.

2. WHAT DOES ONE CALL PERSONS RESPONSIBLE FOR THE DELIVERY OF SERVICES?

A related question which the use of "consumer participation" solves is that of what does one call the persons who are responsible for creating and delivering a service if the recipients are referred to as "citizens." Presumably, these persons responsible for making the product available are citizens also and some of them may exist in life situations similar to those of citizens on the receiving end. Proponents of citizen participation tend to

assume that "citizen" is to some extent synonymous with "poor" or "disadvantaged." The synonymous usage indicates an implied egalitarian thrust.

3. POPULARITY OF THE CONSUMER PROTECTION MOVEMENT

The accelerating progress of consumerism and the consumer advocacy or consumer protection movement over the past few years has given the term "consumer" a sudden boost in general currency. Although the consumers' movement, as led and exemplified by Ralph Nader *et al.*, has little, if any, connection with the demands made by public program recipients for consumer participation in the planning and running of those programs, the popularity of the word "consumer" has resulted in part from the dramatic growth of the former social movement.

It is instructive to ponder the question of why consumer protection and consumer participation are not more closely linked conceptually or in practical politics. In a purely logical sense, there seem to be obvious parallels and coincidences of interest. A major difference, of course, is that the persons attracted to the two movements differ in their social-economic class standing and in other important ways. Two similarities: (a) The consumers' movement works to have consumer representatives placed on the boards of major corporations on the assumption that present board members hold foremost their own and the companies' interests, allowing consumer interests to be ignored or downplayed. A parallel

situation exists in the area of health for the poor. Major medical institutions have many members who are themselves consumers of medical care and are members in good standing of the general public, but advocates of consumer participation in neighborhood health programs maintain that the governors are unwilling and unable to represent the group of consumers most affected by their programs.

(b) An even closer parallel exists in some of the interests of the two movements. An historical high-point of the consumer movement was the passage of Pure Food and Drug legislation. We hear today the cry for fair labelling of drug products, for the marketing of drugs by their generic name rather than their trademark name, of scandals over the size of drug company profits and about impressive variations in the price of the same drug as supplied by different firms within a small geographic area. Clearly, this is more than just a quasi-medical issue. The cost of medical drugs is a matter of paramount concern to the clients of neighborhood health programs sponsored by the government.[1] At any rate, the consumer movement remains largely middle-class in its orientation, while the persons who suffer most from the problems to which the movement addresses itself practice a consumerism tied directly to

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[1]Perhaps one reason that this overlap of interests has not brought the movements closer together -- aside from class differences -- is that neighborhood health centers tend to provide in-house pharmacies or to arrange for the purchase of drugs by their patients at reduced rates from a local establishment.

a more pressing need -- that of medical care and treatment. Drugs are a part of such service, but cannot be felt to be of special importance to poor families whose lack in this area is so great.

4. THE SEARCH FOR NEW LABELS

Because of the dynamic process according to which government programs are conceived, proposed, funded, and evaluated, there is a constant search for new labels to use in selling old programs. Novelty and innovation have enjoyed a heyday in terms of governmental and societal approval and courtship. The continuing phenomenon of the displacement of goals requires for its sustenance a steady stream of new phrases, new catchwords, new terms. Consumer participation is one of these. The new labels do, of course, reflect actual changes and modifications, but, to a certain extent, they have a life of their own, and they are conceived, live and die in partial isolation from the concepts, programs and institutional behaviors for which they are flags, banners, and flagbearers.

When a program or a policy becomes more politically vulnerable or more of a liability to its sponsors and supporters, it becomes necessary not only to change the program or policy itself, but to alter its public image as well. The concept of citizen participation has flirted with bankruptcy -- both intellectual and programmatic. Its creditors -- true to the fashion of imaginative

financiers -- have bailed it out in part by rehousing the old operations in new corporate dress. The new terms are a part and an indication of this process.

5. THE EXPANDING INVASION OF ECONOMIC CONCEPTS

The terms "consumer" and "producer" reflect growing interest on the part of economists in issues of health affairs and other political controversies surrounding the allocation of programmatic resources. In general, economists have not engaged in analysis of the political dynamics of these processes, but their expanding interest in the field, and growing impact upon it, is marked by an advancing invasion of their tools and concepts, and therefore, their words.[2] Others in the field are forced to come to terms with economic ideas and approaches, and to assimilate this influence. Health planners today handle with ease, at least at the surface level, concepts such as cost-benefit, input-output and all the rest.

In a purely economic sense consumer participation can mean simply activity in the role of consumer. Consumers participate when they take part in the markets and sub-markets for medical care, when they avail themselves of the services of neighborhood

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[2]See Rashi Fein, "An Economist's View of the Neighborhood Health Center as a New Social Institution," Medical Care, Vol. 8, No.2 (March-April), pp. 104-107.

health centers, for example.

The growing significance of an economic perspective for neighborhood health programs sponsored by the federal government is caused also by the stage of development of these programs. Since many have been going for more than one year and rely heavily on government funds, the desire to see results is growing. Economists as a rule have played a larger role in the evaluation of recent social programs than they have in the original conception and promulgation of these programs. The distinction between "consumer" and "citizen" touches on the continuing battle of Social Man vs. Economic Man. Do we view the benefits of a medical program more in terms of social consequences or economic? The need to show results imposes on operating programs a perspective that views their clients and users as individuals and groups consuming a definable product. The perspective of consumer participation implies a focus upon aspects of what is consumer -- questions of quantity and quality.

The incursion of a greater economic bias might point to a preference for market mechanisms, for program approaches which attempt to shore up free market systems of health care. This is probably a weak assumption, however, since economists are increasingly interested in how the market system with health care is structurally inadequate and therefore are heavily engaged in devising ways of supporting and elaborating nonmarket solutions.

It has become a trite observation that we are increasingly a society of consumers rather than producers. Our national ambivalence over the role of consumer creates a certain amount of discomfort with the term regardless of its restricted academic or programmatic meanings. The "consumer" is linked in our minds with visions of conspicuous consumption. Another negative connotation of the term is that of passivity. Neither of these notions seem to have direct bearing on the subject at hand, but to mention them serves as a useful reminder that the concept holds latent perjorative meanings which can become more important as the concept evolves.

APPENDIX C: DENVER -- LIST OF PRINCIPAL ACTORS

Dr. Samuel Johnson, former director of Division of Public Health and Preventive Medicine, Dept. of Health and Hosptials

Dr. David Cowen, current Manager, Dept. of Health and Hospitals

Dr. Daniel Benedict, former representative of Denver Medical Society on Denver War on Poverty board of directors, also chairman of DWOP health committee

Dr. J. Philip Clarke, member of Dept. of Health and Hospitals Board of Directors

Dr. Frank Candlin, member of Dept. of Health and Hospitals Board of Directors

Dr. Clyde Stanfield, former Medical Society president and early opponent of the neighborhood health program

Mr. Phil Frieder, Deputy Manager of Dept. of Health and Hospitals

Dr. Arthur Warner, former director of Maternal and Child Care section, neighborhood health program of the Dept. of Health and Hospitals; member of DHH staff opposed to reorganization of the Dept.; current technical advisor to Health Committee, Denver Model Cities program

Mr. Charles Tafoya, member of Lay Advisory Board (defunct) of Eastside Neighborhood Health Center; chairman of first elected Eastside Health Board; current executive director of local Latin American Research and Service Agency

Mr. Clarke Watson, chairman of Lay Advisory Board of Eastside Neighborhood Health Center

Mr. James Chavez, Consultant, Eastside Health Board

Mr. James A. Kent, former head of behavioral science unit, neighborhood health program, Dept. of Health and Hospitals; current director of Foundation for Urban Neighborhood Development; member of DHH staff opposed to reorganization of the Dept.

Dr. Robert Ferguson, author of "Ferguson Report" on management and organization of Dept. of Health and Hospitals

Mr. Thomas Currigan, former mayor of Denver, during development of the neighborhood health program

Mr. Hy Hechter, former supervisor of neighborhood aides at Eastside Neighborhood Health Center; member of DHH staff opposed to reorganization of the Dept.

Mr. Bernard Karshmer, Asst. Deputy Manager, DHH, and Administrative Manager, neighborhood health program

Dr. Frank Woertman, Administrator of Project CHILD and Maternal and Infant Care section of neighborhood health program; member of DHH staff opposed to reorganization of the Dept. who was dismissed, but won his appeal to the local Career Service Board

Mr. Sam Burns, former staff member of behavioral science unit, neighborhood health program; member of DHH staff opposed to reorganization of the Dept.; current staff member of Foundation for Urban Neighborhood Development

Mr. Frank Justice, former Administrator of Eastside Neighborhood Health Center; reassigned following a three month leave of absence after new Eastside Health Board demanded his resignation

Mr. Dan Euell, Administrative Assistant, Eastside Neighborhood Health Center; his resignation was also demanded by the Eastside Health Board, but he continues in this position

Mr. Wesley L. Mack, current chairman of Eastside Health Board; also community organizer for Resident Participation in Denver, Inc., the citizens participation unit of Denver Model Cities program

Mr. Frank Bailey, current chairman of Eastside Action Council, man responsible for appointing Action Council members to serve on the Eastside Health Board

Dr. Leighton Whitaker, former Coordinator of Mental Health Planning, Model Cities program; current head of Community Mental Health division, Dept. of Psychiatry, Univ. of Colorado Medical Center

Mrs. Maxine Kurtz, former Technical Director of Denver Model Cities program, chief draftsman of the program's original application and first year report; current Director of Evaluation, Denver Model Cities program

Mrs. Melinda Saunders, former chairwoman of Health Committee, Denver Model Cities program

Dr. Stuart W. Hollingsworth, Medical Director, Mental Health components, Denver Model Cities Program, an employee of DHH, delegate agency for mental health

Mr. Douglass Carter, Administrative Officer in charge of Mental Health components, Denver Model Cities program, an employee of DHH

APPENDIX D: ST. LOUIS -- LIST OF PRINCIPAL ACTORS AND ORGANIZATIONS

Actors

A. Kay Keiser, OSTI health consultant

Robert Buxbaum, OSTI health consultant

Roger Steffen, former coordinator of YDCC health component

Mrs. Dorothy Stauffer, Director, Department of Social Work, St. Louis Department of Health and Hospitals

A. J. Henley, Administrator, Yeatman Health Center (Director of Health Care, YDCC)

Alphonse Lynch, Executive Director of the YDCC; formerly Coordinator of the Yeatman Neighborhood Center, HDC

Dr. Fred Sargent, Medical Advocate to Health Committee; later a member of professional advisory committee to the Health Committee

Dr. Larry Millner, Director of Planning for Prepaid Health Insurance, Alliance for Regional Community Health, Inc.

Mrs. Arabella Lawrence, Chairwoman, Health Committee; Board member, YDCC

Dr. Max Pepper, Head, Department of Community Medicine, St. Louis University School of Medicine

James Howard, former staff member of St. Louis Health and Welfare Council

Organizations

Organization for Social and Technical Innovation (OSTI) - provided technical assistance to National Service Project cities

Human Development Corporation (HDC) - St. Louis Community Action Agency

Yeatman District Community Corporation (YDCC) - St. Louis National Service Project organization

St. Louis Department of Health and Hospitals - Administrator of local municipal hospitals, and M & I Clinic within Yeatman District

Alliance for Regional Community Health, Inc. (ARCH) - St. Louis regional health planning organization

St. Louis University School of Medicine

Jeff-Vander-Lou (JVL) - community corporation in Yeatman District, incorporated in 1966, rival to the YDCC in many respects

Neighborhood Advisory Council

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