

# **Historical and Organizational Frameworks of Community-Based Health Organizations in the United States**

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This chapter supplies working definitions of community-based health organizations (CBHOs) and their advocate role and then provides two frameworks, historical and organizational, that facilitate an examination of the role, purpose, and functions of CBHOs. Several concepts are introduced that increase our understanding of the many intangible attributes of health from the community perspective. These concepts—community organizing and the building of social capital, social cohesion, social glue, social bridges, the development of a strong civil society, and the community empowerment that follows—all play vital roles in the quality of life and the quality of health outcomes in any community. At the same time, these concepts point to specific areas of community development and empowerment in which CBHOs play a significant role.

Consequently, the chapter also looks at the historical development of community health, leading up to the emergence and growth of CBHOs. It also looks at the organization and structure of CBHOs

and their capacity for empowering communities through development of partnerships that improve health outcomes and other community conditions.

## **Learning Objectives**

- Social, economic, political, cultural, legal, and linguistic forces influence the shape and delivery of health services in general and the development of CBHOs in particular in a given community.
- The growth or demise of community health services is subject to competing national, regional, and local interests, as well as the historical journey unique to each community.
- A receptive political climate, strong social capital, social cohesion, a civil society, and a well-organized advocacy network are essential for community health services to advance.
- The development of community health services in the United States has undergone two major stages and is now entering a third.
- There is renewed interest in neighborhood-based health centers as effective service delivery models, particularly in urban settings, as a result of immigration and migration, the replacement of manufacturing jobs with service sector jobs, and restructured levels of federal and state support to cities.
- The role of government in the development of CBHOs continues to change.
- Improvement in community health outcomes requires that CBHOs develop the technological capacity to plan, advocate, deliver, monitor, and evaluate culturally acceptable preventive and primary services.

## **Working Definitions**

It is important, before discussing important concepts, that all participants have a clear idea of precisely what those concepts mean. To that end, I provide here some definitions of the most important terms we will be encountering throughout this book.

## Community-Based Health Organizations

*Community-based health organizations* are formal, legal structures established by, or together with, community residents, in order to advocate for, secure, increase access to, or provide health and health-related social support services to a community. There are two distinguishing characteristics of CBHOs. The first is their unique ability to serve as a bridge between their constituents and mainstream service delivery systems, thus facilitating access to care. The second is their ability to use their knowledge and cultural identity to build reciprocal relationships with a broad range of government health, social service, civic, educational, and religious institutions to foster coordinated, comprehensive, and culturally appropriate services.

The term *community-based health organizations* is intended to impart the basic philosophical precept of neighborhood-based or locally based entities providing health and social support services to communities or defined populations. CBHOs are presented here not as a category unto themselves but as a subset of *community-based organizations* (CBOs). The primary focus or mission of CBHOs is to intervene in eliminating the causes of poor health as opposed to focusing solely on the health problems themselves. In this context, they provide health education, outreach, and case management services, and sometimes they do so in conjunction with clinical care.

### ***Community***

*Community* is defined here as a group of people who share a geographical space; have common social bonds of status, concerns, or perspectives about specific issues; and assume, depending on the depth and strength of social capital available in that community, the obligations and responsibilities involved in collectively helping one another (Rubin and Rubin, 2001).

### ***Community-Based***

*Community-based* suggests a cadre of residents who, with the involvement of fellow residents, institutions, and other stakeholders, take on a central role in building and empowering their community and its organizations. The synergy that results from community-based

involvement helps garner communitywide involvement and sustain collective efforts in public health actions around concerns identified by residents. *Community-based* is also indicative of collective activities of residents anchored within their community. For example, a hospital may be located in the community but would not be considered community-based because its support, stakeholders, staff, trustees, and investors may not necessarily come from that community.

### ***Community Influence***

How does the community influence health and health behaviors within it? From a sociological perspective, humans do not live in a disorganized fashion. Although we make individual and personal decisions all the time, we can do so only in the context of the family, community, city, country, and larger world in which we live. Sociology has taught us that our social world guides our behavior and life choices in much the same way that the seasons influence our clothing and activities (Macionis, 2005). Another answer, from an urban planning point of view, says, quite simply, that your health is influenced by where you live. It would appear, then, that regardless of the perspective, one's environment or community becomes critically important in terms of its ability to influence health behaviors, activities, and ultimately health outcomes.

Knowledge of how community influences health helps us in various ways. For one thing, it helps us think critically about various "truths." Many of the "truths" that abound about health are not necessarily factual. For example, a popular belief during the 1970s and 1980s was the notion that we are each individually and solely responsible for our own health. Because that idea was accepted by policymakers, it not only drove health policy but also made it easier to blame victims of certain illnesses and praise healthier people for their willpower or superior health behaviors (Byrd and Clayton, 1993). When we understand the influence of community on health, we are better able to think about our beliefs critically and to determine to what extent community or individual behaviors contribute to health outcomes and why.

Knowledge of how community influences health helps us determine how to work effectively within communities to address health concerns. Developing a deeper understanding of how community influences health can shed light on the various factors con-

tributing to the disproportionate incidence of illness and disease among certain racial, ethnic, and socioeconomic groups and explain differences in the availability of funding and providers from one community to the next. As we understand more about the significant influence of community on health, we gain greater clarity in assessing health conditions in a given community. Often this newfound clarity leads to active involvement in development and pursuit of goals that will improve the health of a community.

Knowing how community influences health also helps us value the cultural diversity of every community. The rich diversity of the United States is the result of four centuries of immigration from around the world. There have always been ethnic enclaves of recent newcomers and distinct neighborhoods inhabited by descendants of previous immigrants. The residential pattern of ethnic enclaves helps community members maintain their cultural practices while functioning within the larger social milieu. As the size of an immigrant group grows, it eventually comes to include individuals identified as natural healers in whom the group places its trust regarding matters of health. In such communities, Western “biomedicine” is not necessarily the first course of action but frequently the treatment of last resort. One of the many lessons to be learned from cultural diversity is that group values and experiences influence health behaviors that affect health outcomes.

### ***Health***

In the preamble to its constitution, the World Health Organization defines *health* as “a state of complete physical, mental, and social well-being and not merely as the absence of disease or infirmity.” This broad definition suggests that the well-being of any group of people cannot be viewed in isolation from its history and current conditions. However, the unwillingness to broaden the definition beyond a focus on disease and infirmity, and the repercussions for human health, is rooted in a dramatic shift in the way people viewed the world during the Age of Enlightenment, in the sixteenth and seventeenth centuries. That view, based on a method of “scientific” reasoning that is mechanistic and linear, is often referred to as Cartesian thinking or Cartesian reductionism (Cottingham, 1998; Payer, 1988). The Cartesian paradigm has exerted undue influence on shaping views in every sphere of life for some four hundred

years. It is credited with development of the Western biomedical model that reduced health to mechanical functioning and established strict divisions between mind and body (Capra, 1982).

An important outgrowth of Cartesian reductionism is the contemporary biomedical model, which is essentially concerned with only four things: the diagnosis, the disease, the patient, and the treatment (Foss and Rothenberg, 1987), in that order. The biomedical model is ill-suited to addressing current community health needs in an advanced industrialized society like the United States, for two reasons. One has to do with new knowledge about the etiology of disease, which stresses that in addition to the early biological programming, chronic health risks result over the life course from adverse environments, childhood and adolescent illnesses, nutritional practices, levels of physical activity, and many other influences (Brunner, 2000). The other has to do with the fact that over the course of the past hundred years, infectious epidemics and pandemics have become less prevalent, replaced by chronic illnesses and new epidemics that are more closely associated with behaviors governed by social norms, habits, beliefs, and shared characteristics and perspectives.

As a result, despite the phenomenal scientific advancements and accomplishments in medicine in recent decades, the biomedical model has proved inadequate to address health-related behaviors and their health outcomes. The poor fit of this model with current health problems is particularly noticeable in non-Western and nonmainstream communities in the United States (Bayne Smith, 1996b). In fact, the biomedical definition of health as the absence of disease tended to ignore group history and in so doing did not address the idea of community health. As a result, it is only in the past twenty to thirty years that medicine in the United States has become concerned with the disparity in health between groups or communities or with the differences in population and community characteristics that can either contribute to or detract from improving health outcomes. As efforts are made to define health in more comprehensive terms, it is expected that the health of communities will be addressed.

### ***Organization***

An *organization* is an entity built by members of a community to gather and focus information, pressure government and private agencies, conduct protests, contribute to the empowerment of its

members, or create new forms of ownership (Rubin and Rubin, 2001). Organizations bring resources and capacity to educate, empower, and mobilize a community and foster the development of CBHOs as organized, structured responses to health concerns.

Building organizations presents a difficult challenge for communities where civil society is weak, recollection of historic experiences is an obstacle, or resources, skills, and capacity are lacking. As a result, some communities must first focus on providing their constituents with social support services to assist them in breaking down barriers that stand in the way of their quest for a community organization to provide health services.

## Health Advocate

A *health advocate* seeks to influence decisions about health policy and the allocation of health resources in order to improve community health outcomes. As health advocates, CBHOs employ organized strategies and actions while holding themselves accountable to the communities on whose behalf they advocate.

Health advocates strive to improve health outcomes for their community by gaining a voice and a place at the table of relevant institutions and agencies where decisions affecting community health are made. The strength of CBHO advocacy efforts lies in the fact that access issues are felt most acutely at the local level. Therefore, CBHOs are in a unique position to articulate social issues that affect health as well as local approaches to health improvement. In this context, their goal is to change the relationships of power between centers of decision making and the people and communities affected by those decisions.

Since the terrorist attacks of September 11, 2001, perceptions of health and the impact of political, social, and economic events on the health of a given community have changed. As a result, along with new concerns about air pollution and air quality and the availability, supply, and quality of vaccines against smallpox, anthrax, and various other biological and chemical agents, there are also new concerns about “community health.” In that regard, the very presence of nuclear power plants in our communities seems now more than ever to pose an increased health threat. In this environment of heightened awareness of terrorism, one of the equally pressing health needs that

has surfaced is for ongoing mental health services at a time when resources for mental health services in several states and communities have either been reduced or evaporated entirely. Though sometimes considered not as tangible as physical health, the mental health and other nonphysical characteristics of communities carry important ramifications for the health of a community.

## Community Health

Before we can define *community health*, we must recognize that in the United States, some communities are subject to greater environmental health risks and deficits, such as low social capital and weak civil society, as a result of distinct population characteristics. The residents of these communities are not only assigned a lower rank in the U.S. social hierarchy but are also at greater distance politically and economically from all those above them. In addition, residents of these communities tend not to form advocacy organizations, nor are they part of social networks that can facilitate access to services and resources relative to their health care needs (Murray, Frenk, and Gakidou, 2001). It is in these communities that CBHOs are well positioned to organize residents and focus their efforts. The emphasis must be on the building of social capital and social cohesion and on community development and empowerment resulting from an engaged civil society. The desired end product is empowered communities that develop the organizational capacity to advocate for improved health outcomes.

## Community Building, Social Capital, Social Cohesion, and Civil Society

The term *community building* broadly describes the work of organizing a community and creating linkages at various levels. The concept of building *social capital* is more complex. Social capital is not the same as economic capital. Economic capital is most often measured individually, whereas social capital is a collective assessment of specific kinds of resources within a community, group, or society. Thus *capital* in a community context refers to the supply of less discernible resources: trust, duty, reciprocity, responsibility, obligation, and control. In the absence of these intangible forms

of social capital, communities, groups, and sometimes whole societies become disorganized and destabilized.

Similarly, *social cohesion* is a collective or ecological measure of a community. Ichiro Kawachi and Lisa Berkman (2000) explain that social cohesion refers to the absence of latent group conflict and the presence of strong social bonds (capital) and a strong civil society. *Civil society* is used to describe the web of voluntary groups and associations that exist in empowered, well-developed communities. Civil society serves as a bridge between people and government to protect people, help meet needs unmet by government, and function as the social glue that holds society together (Kawachi and Berkman, 2000). The significance of these terms lies in their connection to health outcomes, demonstrated through a body of research that has emerged over the past four decades (Schoenbach, Kaplan, Fredman, and Kleinbaum, 1986; Wilkinson, 1996; and Kawachi and others, 1996). Research to determine how social capital, social cohesion, and civil society help build community and move it toward the goal of improving health outcomes must include studies that examine poor health outcomes in communities with diminished social capital (Berkman and Syme, 1979), communities in which social capital and social cohesion exert a positive influence on the use of preventive health services (Kawachi and Berkman, 2000), and organized advocacy efforts in socially cohesive communities that have been shown to preserve community programs and services intended to be derailed by budget cuts (Coleman, 1988).

Given these explanations of community-related concepts, how is health defined from a community perspective? To do this, it is necessary to consider the larger milieu in which a given community is embedded, including economic development, quality of education, religion, hopes, goals, government structures, and cultural customs. It is equally important to weigh some of the emerging and controversial areas, such as the association between health outcomes and the social capital, social cohesion, and civil society in a given community.

Consequently, the definition of community health goes beyond the “absence of disease” paradigm to place greater emphasis on the “whole person within the environment” configuration. This broader, more encompassing definition, in which health is seen as connected to community, has long been understood by many health advocates

as having direct import for the kinds of approaches used to deliver services. The broader definitions of community health have been the basis of arguments used by proponents since the 1940s to advance the idea of moving the nation toward health service delivery models known as community-oriented primary care or community medicine (Kark and Abramson, 1982).

### **Community Health, CBHOs, and Advocacy**

Most community residents and some of the health professionals that serve them are very aware that community health is affected by a host of factors. Some of these factors include culture, traditions, the status of women, rates of unemployment, and domestic violence; levels of hopelessness, social cohesion, and social capital; the strength of civil society; increasing rates of sexually transmitted diseases, including HIV/AIDS; and environmental injustice (Bayne Smith, 1996b; Kawachi and Berkman, 2000; Putnam, 1993; Gamble, 2002; Freudenberg, 1984).

Residents living in low-income, racial, ethnic, immigrant, and other underserved communities have been organizing for half a century to create CBHOs to address their own long-standing health problems. The challenge is how to structure mutually beneficial arrangements among community residents, health professionals both in and outside of government, and the health industry as a whole, in an effort to deliver a range of primary care and social support services to many different types of communities.

Unlike community residents and their CBHOs, health agencies and departments at city, state, or federal levels have only recently recognized the wide-ranging factors affecting community health. Although the process of recognition has been slow, the fact that there is movement toward incorporating community into the definition and programming of health services is encouraging. As government health systems pay more attention to community health services, their efforts are fueled by an emerging body of research that carefully documents the important connections between the health and economic status of a community, its access to health care, and associations between aspects of work and health (Leon and Walt, 2001; Engels, [1845] 1987; Marmot and others, 1997;

Bayne Smith, Graham, Mason, and Drossman, 2004; Bayne Smith and others, 2004; Leigh, Jimenez, Lee, and Andrews, 2002). Much of the movement that we currently witness on the part of government health systems is due in large measure to increased community advocacy to secure health services. Of critical significance to the advocacy efforts on the part of communities is the interpretation of the word *organization* and its importance to the term *CBHO*.

## Questions About CBHOs and Advocacy

Why study CBHOs? The most significant reason for studying CBHOs is simply that CBHOs represent a key component of successful health delivery in the United States. Surprisingly, there is a dearth of literature on the subject. Unquestionably, much has been written about different kinds of community-based services, including primary and ambulatory care, emergency care, complementary and alternative medical care, and home health care. There is also an abundant literature on community health centers (CHCs). However, CBHOs are a distinct model of community-based health services that places critical emphasis on resident involvement in defining not only community health needs but also the responses generated.

Faced with long-term, persistent challenges in addressing health disparities, U.S. health providers and policymakers are reluctantly and slowly being forced to see that to serve culturally diverse populations more effectively, greater emphasis must be placed on a community-oriented vision of primary care, rather than on hospital-based care. As a result, after investing heavily for almost a century in the development of hospital-based services, the health care industry has been forced in the past twenty-five years to move away from caring for patients in the hospital setting and provide more services in the ambulatory care setting. These changes continue to be driven by a combination of recent demographic trends in the United States and market forces such as managed care organizations (MCOs).

Understanding that the shift to community-based care has not been uniform across the U.S. population led us to inquire about the importance of advocacy as an important function of CBHOs. Statistics on health care utilization from the National Center for Health Statistics (NCHS) at the Centers for Disease Control and

Prevention (CDC) (2003, tab. 83; McCaig and Ly, 2002) were useful in shedding some light on the importance of advocacy:

- The rates of visits to physicians differ by age, gender, race, socioeconomic status, and insurance.
- In 1998, Americans age seventy-five and older had the highest number of ambulatory care visits, 764 visits per 100 persons.
- Women made 1.4 visits to a physician for every visit by a man.
- Whites had more visits to physicians' offices than blacks.
- More blacks than whites used the emergency room or a hospital outpatient department as their primary source of care in 2000, indicating a lack of both insurance coverage and a regular source of care.

Although mandatory Medicaid managed care did increase physician visits for the poor, one of its intended goals was to decrease emergency room visits, and it has not done so. Further, the population of the United States grew by 3.8 percent over the past decade, but the number of emergency room visits increased from 90.5 million in 1994 to 94.8 million in 1998, representing a 4.75 percent increase in just four years (Mezey, 2002, p. 185). Moreover, while approximately 47 percent of the patients receiving emergency care in 2000 had an urgent or emergent condition, the other half did not need the expensive, intense resources of an emergency room (McCaig and Ly, 2002).

The advocacy work of CBHOs on behalf of underserved communities is in part aimed at rectifying these statistics. CBHOs have traditionally advocated for the uninsured to balance market forces driving the managed care (MC) and Medicaid managed care (MMC) organizations that do not extend insurance coverage to everyone. The uninsured are the group for which there is greatest concern, and they are one of the groups that are most often served by CBHOs. In addition to the serious problems of access to care for the uninsured and the heavy reliance on and inappropriate use of emergency rooms that continues, there is a deeper concern regarding the cultural and linguistic appropriateness of managed care services at the community level. CBHOs provide an alternative, as they are largely representative of the communities they serve.

The advocacy efforts of CBHOs becomes even more significant in view of the fact that to date, MC and MMC organizations have not

established a notable record of accomplishment in reaching out and involving community leaders in policy and decision-making capacities. This is something that CBHOs have been successful at doing. Because of their success, CBHOs have also reached out to explore and develop partnerships with managed care organizations that can ultimately expand the reach of MC and MMC organizations into communities they did not historically serve, while at the same time enhancing the capacity of CBHOs. This trend is expected to continue and requires careful study.

Although it must be acknowledged that some positive movement is occurring, serious concerns remain. A recent report of the Institute of Medicine (2003) of the National Academies indicates that racial and ethnic minorities tend to receive a lower quality of health care than nonminorities, even when controlling for access factors such as health insurance and income, and that the sources of these disparities are rooted in the complexity of past and current inequities involving the entire health system bureaucracy, from administrators to all levels of health care professionals, as well as the patients themselves.

In the face of unrelenting health disparities in the United States, what can CBHOs in their role as health advocates do to help eliminate them? To answer this question, we employ two different frameworks. The first examines historical developments in community-based health services, primarily in the United States, and discusses some of the initial concepts, policies, and programs on which CBHOs now rest. The second framework looks at how CBHOs are organized and examines their roles and functions particularly as they relate to resource requirements, consumer needs, and types of service provided.

## **Historical Framework: Development of Community Health Services in the United States**

Evidence exists that from the very earliest civilizations, humans have been concerned with community health. As early as 25,000 B.C., carvings showing physical deformities were made on cave walls in Spain. Later Chinese carvings on tortoise shells depict health practices in the Xia and Shang dynasties (twenty-first to eleventh centuries B.C.) and also the digging of water wells and ditches (Green

and Ottoson, 1994). Excavated sites of communities thousands of years old have revealed bathrooms, drains, covered sewers, and drinking water supply systems in societies of the Nile region, in ancient Indian cities, and throughout the Greco-Roman world (Green and Ottoson, 1994; Rosen, 1958).

## Lessons from the Past

One of the great lessons regarding community health dates from the Late Middle Ages. In 1095, the Christian Byzantine emperor Alexius I asked Pope Urban II for help in expelling the Muslim Seljuk Turks, who were invading his empire (in Asia Minor, modern Turkey) from the east. The pope willingly complied and decided that if his Christian armies were going that far, they might as well continue on to Jerusalem and “liberate” the Christian holy places there, thus initiating nearly two centuries of religious wars between Christianity and Islam known as the Crusades (Spielvogel, 2005). The massive movement of troops and other people from one region to another during the Crusades contributed to large-scale health problems. Diseases such as cholera, bubonic plague, and pulmonary anthrax spread from one country to another along the migrants’ path, killing thousands of people. In addition, as trade routes opened up and ships moved from one port to another in Asia, Africa, Europe, and the Middle East, infectious diseases traveled with them. Drastic measures had to be taken at the time to prevent epidemics. Some European nations instituted quarantine stations and ordered newcomers to remain there for several months until they were deemed free of disease. These measures were not highly effective (McNeill, 1977).

The sixteenth century ushered in the Enlightenment (1600–1800), and with it came an initial understanding of disease processes. Although the twentieth century brought relief from the earlier pandemics and epidemics, it ended with the emergence of new epidemics (HIV/AIDS) and potential epidemics (Ebola, SARS). Note that throughout history, most pandemics and epidemics have been interpreted as divine punishment for the sins of humans. Nevertheless, we have abundant evidence of carefully planned, if misguided, public health efforts aimed at protecting the community, even during the Dark Ages. It appears, then, that there has

been some level of recognition for millennia that although there was some individual responsibility for health, there was also the need for some societal or communitywide approach. In fact, most of the earliest public health activity was born out of the recognition that when faced with transmissible diseases, preventive action at the community level is necessary.

## The U.S. Context

From 1600 to the mid-1800s, major European countries set out to colonize the rest of the world, including what is now the United States. Colonization had an impact on the health of every new group encountered as populations around the world were introduced to theretofore unknown diseases. Sometimes infectious disease like measles was even spread intentionally to aid in the subjugation of a population, as was the case when the Spanish colonized South America. Later, once the new order had been established, the European nation might provide whatever remedies were in fashion. Similar stories were played out on the African continent.

The taking of the North American continent was facilitated to a large extent by that familiar process. As a result of European diseases, the Huron nation was reduced by half, 90 percent of the native population along the East Coast were killed, and the Eskimo and Inuit populations of the Alaskan regions were seriously reduced (Green and Ottoson, 1994). The fact that there was a concerted U.S. military strategy to decimate and subdue survivors of the Native American population and appropriate their land cannot be denied. However, health conditions undoubtedly contributed to the fact that by 1836, many of the remaining tribes readily signed treaties with the U.S. government in which they relinquished millions of acres of land in exchange for medical supplies, physician services, and promises of hospital construction (Kaufman and Joseph-Fox, 1996). In summary, disease eliminated much of the opposition to the early colonizers and later facilitated the European conquest of the American continents with much less bloodshed than had been anticipated.

People in the United States during the colonial era and the early days of the republic also suffered from pandemics of such diseases as yellow fever, smallpox, measles, typhus, and scarlet fever that resulted in deaths in the tens of thousands. These outbreaks

ended only after they had run their course through a given population or locale. Some colonies took action by setting up citizens' committees to provide communitywide direction for responding to a pandemic, but this kind of guidance was usually ineffective. For the most part, there was little capacity or effort in the colonial years to develop health policy on any uniform or consistent scale. Individual colonies took small steps to require the mandatory recording of births and deaths, but this was a time when life expectancy rarely exceeded forty-five years, health science and health services were unheard of, and community action regarding health occurred only as a response to outbreaks.

Health care in colonial communities, such as it was, occurred essentially through local efforts of residents to address the health concerns and events they faced, as no government health systems existed. Nevertheless, throughout the colonies, in almost every culture or group, health events such as births were treated as community events. Slave women gave birth to their children assisted by midwives who were themselves slaves. In fact, the midwifery skills of these slave women were relied on by both black and white women (Holmes, 1986). For some Native American women, childbirth was also a community event in which they were assisted by their mothers, mothers-in-law, and midwives (Axtell, 1981).

The spread of infectious disease due to the overcrowded and unsanitary living and working conditions of the Industrial Revolution led to both Engel's radical analysis of the condition of the working classes in Manchester, England ([1845] 1987), and Chadwick's more liberal analysis and report on the health of British workers ([1842] 1965). Engel's analysis blamed the deterioration of health on the rise of capitalism, whereas Chadwick suggested that the deterioration was due to poor sanitation. Chadwick's analysis resulted in the development of boards of health in London, Manchester, and Liverpool in England between 1825 and 1846 and later to boards of health in Massachusetts and New York. A similar examination of the health situation in the northeastern United States by Shattuck (1848) in the mid-nineteenth century served as a guide for the development of public health services in every town and city up through the state level. Ongoing scientific developments, particularly in bacteriology, also forced significant changes in approaches to public health. One of the most significant changes was that medicine gained a larger measure of control and prevention over infectious diseases.

## New Challenges for Public Health

By the third decade of the twentieth century, it became clear that there was a need to begin shifting health resources and other health investments away from infectious diseases, not only into the arenas of personal and individual health but also into community and public health. This would include health promotion and disease prevention services to achieve a balance with the scientific and technological advancements that were well under way. The shift did not occur, and the balance was never struck due largely to the medical profession's continuing efforts from the mid-nineteenth to mid-twentieth centuries to consolidate its authority and become a powerful political force (Starr, 1982). The increasing power of organized medicine resulted in a growth of resources for the development of hospitals, the training of physicians and other health personnel, and biomedical research.

Some analysts believe that as the medical profession became more powerful, public health services suffered. Garrett (2000) contends that during the first two decades of the twentieth century, public health began a downward spiral because of two historical events. One was the implementing of polio quarantines in New York City when only a vaccine would eventually prevent the disease. The other was physicians' countering of Prohibition by readily prescribing alternatives such as opium, laudanum, belladonna, absinthe, marijuana, and cocaine. In defense of public health, it must be noted that although all societies suffer ups and downs in public health, the United States was successful in conquering polio and many other diseases.

As a result of the growth and consolidation process in the medical profession, public health was forced to shift its focus from larger environmental and social issues to personal hygiene and the transmission of infectious diseases, which required more reliance on the techniques of medicine. A main source of the territorial conflict between medicine and public health in the early decades of the twentieth century was the reluctance of doctors in private practice to meet reporting requirements for infectious diseases, such as tuberculosis and venereal disease. In addition, many doctors in private practice, supported by fees for service, did not see the need to cooperate with public health authorities in the establishment of publicly supported health centers for coordinating preventive medical

treatment for individuals who could not afford to pay a private fee (Starr, 1982).

Thus it was clear by the early twentieth century that the poor were increasingly marginalized and did not benefit equitably from advancements in health care because initially the major source of care for the poor was charity, followed gradually by local government responsibility for indigent care (Williams and Torrens, 1999). Public health nurses and voluntary health agencies historically provided outreach, education, and some primary care services in poor communities, but by the 1930s, there were huge differences in health status, based on class, race, and ethnicity, as well as between urban and rural communities (La Viest, 2002). It had also become clear that changes in U.S. immigration policies in the 1960s led to changes in the demographic makeup of the nation, creating dense concentrations of nonwhite native-born and immigrant populations, especially in its larger urban metropolises. These multiple population segments of racial and ethnic groups, immigrants, and the poor and near-poor contribute to the difficulty of gaining access to the many benefits of Western medicine in a culturally acceptable service delivery format.

## Community Health in a Diverse Nation

Initial efforts to deal with the growing disparity in health suffered by the poor tended to be made by concerned community members. Government support and programs would follow, but much later. The development of public health services in New York City provides a clear and typical example of this trend in the delivery of health services to new immigrant populations.

Throughout the nineteenth century, the New York City Council would establish a board of health during an outbreak of disease; once the disease had subsided, the board would be allowed to disappear. Volunteer reformers, made up mostly of middle- and upper-class New Yorkers, advocated for and were able to garner the required political support to eventually establish a permanent department of health in the city. A major catalyst for these advocacy efforts was the deplorable housing conditions of the ever-increasing numbers of immigrants in the city. Reformers focused the city's attention on the growing problems of slum housing, in which the population was increasing by an

average of 250,000 immigrants per year between 1866 and 1870 (Duffy, 1974, p. 191).

Health problems associated with infectious diseases such as yellow fever, cholera, tuberculosis, and smallpox continued during the remaining years of the nineteenth century. Each shipload of immigrants that pulled into a New York City port therefore delivered a potential health hazard. Early efforts by New York City to quarantine new arrivals were later taken over by state quarantine officers, who improved processing and screening standards by the beginning of the twentieth century, making it possible to provide health services to new arrivals with infectious diseases (Duffy, 1974, p. 199).

A century later, New York City again became a city overflowing with new immigrants. The Hart-Cellar Immigration Act of 1965 superseded the quota system of the McCarran-Walter Act of 1924 and for the first time in U.S. history dramatically increased the numbers of immigrants from non-Indo-European countries, albeit temporarily. In 1985, immigration reform changed the laws once again to restrict the flow of nonwhite immigrants. Even so, as of 1995, an estimated 33 percent of the city's population was foreign-born, and approximately another 20 percent were the offspring of immigrants (New York City Department of City Planning, 1996, p. 14). Health services to immigrants now had a completely different focus. The newest immigrants and the New York City ethnic immigrant enclaves into which they moved faced a radically different set of health issues than their counterparts did a century earlier. Health problems for the most recent newcomers, as for the general population, consisted primarily of long-term chronic diseases rather than short-term infectious diseases. At the same time, the new arrivals also faced complicated new immigration laws that served to limit and even block their access to health care services.

By the 1960s, the nation had eradicated most of the worst infectious diseases in the United States, and in 1977, the global community experienced its last case of smallpox (Hopkins, 1989). Looking back, we now realize that recognition of this success by the medical community in the late 1970s contributed to drastic reductions in budgets for health promotion and education. Unfortunately, this occurred immediately prior to the onslaught of the HIV/AIDS pandemic of the early 1980s. Moreover, these budget cuts, together with restrictions on immigrant health care entitlement benefits, served

to discourage the use of preventive services by the poor, newly arrived, and underserved.

## Unmet Health Needs

With or without government resources, communities have always devised methods to deal with illness. For example, Native Americans had abundant healing practices, focused on balancing the physical, spiritual, emotional, and social aspects of the individual. Sickness was seen as an imbalance, an absence of harmony (Kaufman and Joseph-Fox, 1996). These beliefs were at odds with mainstream American medicine, whose views were voiced by Dr. Benjamin Rush in a paper titled “An Inquiry into the Natural History of Medicine Among the Indians,” written in 1793, in which he concluded that “we have no discoveries in the *materia medica* to hope for from the Indians in North-America.” Despite disparaging criticisms from learned men, “Indian cures” were quite popular and marketable among the general public.

As we now know, much greater by comparison than the decimation of Native American tribes through warfare and the submersion of Indian culture was the neglect of their health needs. In fact, the spread of tuberculosis, trachoma, and other diseases among the Native peoples eventually prompted such public outrage that President Taft urged Congress in 1921 to pass the Snyder Act, mandating congressional appropriations for the “relief of distress and conservation of health” among Native Americans (Kaufman and Joseph-Fox, 1996).

### *Unmet Health Needs and Mainstream Medicine: Two Major Concerns*

A long-standing concern in the health arena has to do with the economic controls exercised by the health care industry. Health service delivery in the United States was ad hoc and uncoordinated until the beginning of the twentieth century. However, even before there was any significant level of professional organization among practitioners of medicine, they viewed the poor as useful in terms of training and practice opportunities but evinced little desire to provide ongoing medical care for them, due primarily to financial considerations. This unwillingness to serve the poor deepened over

time and became so strong that between 1870 and 1910, the poorer states lost physicians relative to population while the wealthier states gained them. For example, in 1870, there was one doctor for every 894 residents in South Carolina, compared to one doctor for every 712 residents in Massachusetts; by 1910, the number of residents per doctor had risen to 1,170 in South Carolina and fallen to 497 in Massachusetts (Starr, 1982, pp. 124–125).

The second concern regarding unmet health needs and mainstream medicine follows the first, because economics and politics are inextricably intertwined. The ability of organized medicine to protect its economic interests flows in no small measure from its reinvention as an organized political entity. The health care industry became organized politically by the mid-1960s, with sufficient lobbying power to influence legislation to protect its interests. However, this very ability on the part of organized medicine begs the question of the distribution of political power in a so-called democracy. The concern here, notwithstanding the intent of organized medicine to protect its interests, is that the unmet health needs of certain groups and communities in the United States appear to be directly proportionate to the level of political power those groups exercise in the society. In a study on political empowerment and health status of African Americans conducted in 176 cities in thirty-two states, Thomas La Viest (1992) measured black political power in two ways: relative black political power, which is the proportion of blacks on the city council divided by the proportion of blacks in the voting-age population, and absolute black political power, which is the percentage of city council members who are black, indicating the level at which African Americans are empowered to control the political and policymaking apparatus of the city. The study confirmed the hypothesis that a higher level of black political power relative to the black voting-age population is associated with lower black postneonatal mortality, but absolute black political power is not (see also Dye and Renick, 1981).

### *Understanding Why Health Needs Go Unmet*

The historical lack of political will or interest on the part of decision makers in addressing the health needs of the poor, newcomers, and the uninsured and underinsured has not changed in almost a century. Why? Several reasons stand out, the first of which is that poverty

makes excessive demands on the poor for their day-to-day survival leaving them with few material resources and little physical energy to invest in advocacy and political activity, which are the only ways to effect political change. Second, a large number of newcomers reside in poor communities, and lacking U.S. citizenship upon arrival, they are unable to influence the political process through the power of their vote. This is to say they have no political power through which to lobby for social change for at least the first five years they legally reside in the United States. The third reason encompasses the first two in that the combined forces of poverty, noncitizenship, and a lack of acculturation render some poor communities marginalized and uninitiated politically, and so they are not always aware that health care must be regarded as a human right and a public good. Neither do they understand that the means by which human rights and public goods are distributed is political, requiring political participation and the acquisition of advocacy skills.

Far worse than the slow development of organized political approaches to issues affecting their community are the attitudes toward elections and politics held by many members of the voting public. Their diminishing presence at the polls over the past few decades reflects feelings of apathy, bitterness, distrust, and disenchantment with the political process and the empty promises of elected officials. These sentiments are evident in all sectors of the population, regardless of income, race, gender, or locality, but it is most counterproductive for the poor, who have the least access to services and other resources and public goods in U.S. society. In addition, elected officials feel free to ignore poor communities because of the perception that they don't vote.

Another compelling reason that the health needs of some communities remain unmet is that the most recent newcomer groups differ greatly in terms of race, language, ethnicity, and culture, from the German, Irish, Jewish, and Italian immigrant groups who came in the late 1800s and early 1900s. Most of these immigrants were fair-skinned Europeans, not too different from the majority populations already settled in the United States. They could blend in fairly easily. This is not true for many of the more recent newcomers. Being nonwhite has always constituted a major marker of difference in the United States.

Historically, race in the United States has served as the basis for denial of social justice and access to resources and critical services. However, it is now of serious concern that in the opening decade of the twenty-first century, the burden of health disparities in the nation continues to fall primarily on the poor, a disproportionate number of whom are members of racial and ethnic populations. The significance of this difference and its impact on access to care becomes even more pronounced in view of the fact that in 1965, when immigration opened up to permit entry of racially and ethnically different newcomers, the majority of health policymakers, physicians, and industry leaders in the 1960s and 1970s were predominantly white and male. These health leaders, for the most part, have historically been the least knowledgeable about how to serve people who are culturally, racially, or ethnically different.

In addition, poor people lack the resources necessary to practice preventive health care. In the case of immigrants, they also lack knowledge about the complexity of the U.S. health care system and hence feel intimidated by it. The result is a deep-seated reluctance to make use of the U.S. health care system except in emergencies. Another source of reluctance to use mainstream health services is the presence among some racial and ethnic groups of their own healers and practitioners of culturally based health customs, such as Santeria, Candomble, and Voodoo (Gregory, 1987). Further, the relative ease of travel today facilitates access to all of the culturally prescribed tools, equipment, and other resources required to maintain customary health practices, beneficial or not (Korin, 1985).

## Community Responses

Whether the issue is barriers to health care access or cultural preferences in terms of health care practices and behaviors, several studies have documented the disproportionately worse health status among the poor, underserved, immigrant, and uninsured populations in both urban and rural settings (Fruchter, Boyce, and Hunt, 1980; O'Toole, Gibbon, Hanusa, and Fine, 1999; see also Fruchter and others, 1980). Activists, advocates, and organizers in poor communities across the United States had become increasingly aware by the late 1960s of the negative health conditions in their neighborhoods.

In response to this situation, many of these communities did what other marginalized groups have done historically in the absence of family ties, supportive relationships, or the assistance of the larger society: they developed their own community-based organizations to address their unmet health needs. And these community-based organizations became the harbingers of CBHOs. In some poor communities, CBHOs continue to serve as the primary resource for health, social support, and immigration-related services (Bayne Smith, 1996a).

Developing local mechanisms to meet community needs is not a new response. In the twentieth century, working-class immigrants on Manhattan's Lower East Side contracted with five hundred physicians to provide medical services to members of their organizations and benevolent societies (Sardell, 1988). The Cincinnati Social Unit Plan was developed toward the end of the Progressive Era (around 1918) by activists and residents in poor areas to provide a variety of services including health services. The small-scale success of this program aroused opposition from doctors, however, and the Cincinnati Plan soon faded away (Betten and Austin, 1990). Other underserved groups also developed local community-based efforts to respond to health needs. The National Medical Association (NMA), an organization of black physicians, and the Medical Committee for Human Rights (MCHR), organized by both black and white health professionals to provide medical services in various southern states during the civil rights era, coordinated health projects with local black and medical community workers. By 1966, the MCHR had branches in thirty northern and southern cities (McBride, 1994). Despite an ongoing struggle to build capacity and to acquire sufficient resources, local CBHOs continue to be a primary source of health care in their communities.

### Government Support of Community Health Services: Two Phases of Development

Throughout U.S. history, communities have designed a variety of ways to respond to the health care needs of its residents. Those responses evolved into different structures, depending on the needs of the community being served; the skills, resources, and commitment they are able to garner from community stakeholders; and

the social, political, and economic climate at the time those responses were being developed. As noted earlier, for most poor communities, the usual pattern of accessing health care was first to develop a local community-based health service and eventually, with the input and support of concerned members of the middle and upper classes, exert political pressure to ultimately obtain government support.

The push for government support went through two broad phases. In the lengthy first phase, political advocacy and activism helped establish some responses to local health needs of the poor in the eighteenth and nineteenth centuries. These responses occurred primarily in the form of dispensaries and the development of outpatient departments in hospitals. It must be noted, however, that by the time dispensaries met their demise in the early 1900s, local departments of health in large cities such as New York were already experimenting with the establishment of health district centers to provide medical care to residents, especially maternal and children's health care. Here too, as was done with dispensaries, organized medicine moved quickly to limit not only public funding for health district centers but also the kinds of health services that could be offered. The combined forces of these two actions served to drastically cut back the operations of most health district centers by the mid-1950s (Sardell, 1988).

In the second phase, advocates of community health services persevered in developing policy networks. Their efforts eventually gained congressional mandates allowing several forms of community health services to resurface by 1965 and again in the 1970s, each time with a different configuration, name, and government classification.

### ***Phase 1: Dispensaries and Maternal Child Health Programs***

The first phase of government support for health care services at the community level was influenced heavily by events in eighteenth-century England, where the first dispensary, known as the Dispensary of the Infant Poor, opened in London in 1769 (Rosen, 1958). The dispensary model was later transferred to the United States and became the major source of free and subsequently low-cost medical care and medications for the poor. Prior to the arrival of dispensaries in the United States, health care delivered by physicians was

provided in the homes of wealthy patients who could afford to pay doctors to make house calls (Ehrenreich and English, 1973). However, dispensaries proved to be acceptable in meeting the health care needs of the poor and did so from the latter part of the eighteenth century through the first few decades of the twentieth century (Sardell, 1988). At the same time that health care was being provided for the poor in dispensaries, health services for the rich—and indeed the entire health care delivery system—was moving from the home to hospitals. The oldest hospitals were initially developed as alms houses to serve the poor (Rosner, 1979). These include Pennsylvania Hospital in Philadelphia, built in 1751; New York Hospital in New York City, built in 1791; and general hospitals in Baltimore, Cincinnati, and Savannah built in 1825 (Rosen, 1958).

By the early decades of the twentieth century, the convergence of increased scientific knowledge, discoveries of new medicines and treatment capabilities, and improved surgical methods all became centralized. Health care personnel were brought together with the rapidly emerging technologies in one place: hospitals. This concentration of resources ushered in the role of hospitals as the hub of all health-related activity in the nation (Williams and Torrens, 1999). Unfortunately, as hospitals blossomed into this new role, by the 1920s, dispensaries disappeared.

Alice Sardell (1988) suggests two major reasons for the demise of dispensaries. One can be found in the way they were structured. Dispensaries functioned as outpatient clinics serving as a training site for young physicians. When the Flexner Report on medical education in the United States and Canada was published in 1910, it forced major changes in the teaching of medicine following the European model, creating a focus on the sciences and research that was best anchored in modern hospitals. The other reason dispensaries did not survive is that the newly created and energized medical societies organized politically to conduct a campaign, beginning in 1890, against “dispensary abuse” by individuals who could afford to pay for care. The fundamental goal, of course, was to do away with any competition, as the majority of U.S. physicians were already practicing fee-for-service medicine, outside of hospitals, by the last part of the nineteenth century. The political campaign against dispensaries resulted in a 1899 law mandating that poor families undergo means testing to determine their eligibility for dispensary services.

This law created, in effect, a “two-class” system of health services (Sardell, 1988). Means testing went on to become firmly entrenched in the United States as the preferred method for rationing health or any other form of benefits or services for the poor.

In addition to dispensaries, early maternal child health (MCH) programs were significant. As early as 1912, the Children’s Bureau, a federal agency, was established out of concerns about child labor and child abuse. As a result of the work of that agency, particularly its reports on the high incidence of maternal and infant mortality, legislation in the 1920s and 1930s authorized grants to the states to provide medical services to mothers and children; these services were usually provided at local health district centers. Later, the Social Security Act of 1935 established federal-state cooperative programs to provide preventive health services in the areas of MCH, crippled children, and child welfare (Davis and Millman, 1983). MCH programs, designed to reduce maternal and infant mortality, were substantially altered over the course of the next forty years through amendments that added a variety of other health categories. From its inception, MCH programs and the many other services provided under the MCH umbrella have been a source of struggle between state and local health agencies.

### ***Phase 2: Federally Funded Community Health Programs***

The second critical phase of government support for community-based health services occurred in two stages: from the mid-1960s to the mid-1970s and from the mid-1970s to the present. The first stage grew out of the Johnson administration’s War on Poverty. The Economic Opportunity Act of 1964 established the Office of Economic Opportunity (OEO), and radically new policies were put in place to implement the Neighborhood Health Center program and later the Community Health Center program that would make health care and other services available to the poor.

The Neighborhood Health Center (NHC) program was designed to deliver comprehensive health services for the poor. NHCs were to train, employ, and involve neighborhood residents in a combined health service delivery and community-organizing effort that could address health, discriminatory medical care, and community development (McBride, 1994). NHCs adapted this combined approach from the work of Sidney L. Kark and his colleagues. Kark

was an early founder and world authority on community-oriented primary care and community medicine. According to Kark and Abramson (1982), community medicine was defined as “distinguished from other forms of personal health care in the community in that its interest is centered on the community as a whole and the groups of which communities are composed” (p. 21).

This model was not new. Prior to the advent of the hospital, health care in the United States, in its earliest forms, was delivered in the community. Even after the first hospitals appeared, the dispensaries and the district health centers focused on the needs of the communities they served. Nevertheless, this model, taking medical care out of the hospital and back into the community, was viewed as revolutionary and challenging at a time when the country was experiencing change in so many areas: civil rights, students’ rights, the women’s movement, opposition to the Vietnam War, and an influx of immigrants from nations around the globe. One criticism of the NHC program was that it was too expensive per unit of service produced, compared to the services of private physicians (Davis and Millman, 1983). NHCs sustained a few minor legislative assaults in the form of budget cuts and amendments but survived the Nixon and Ford administrations to become institutionalized in 1975 as the Community Health Centers (CHC) program. The failure of these legislative assaults held encouraging implications for the longevity of federally funded health programs. Indeed, the CHC program has survived to this day, with some alterations.

It must be noted that the OEO legislation and the NHC and CHC programs that resulted from it were products of their time. Not only was the economy transforming and growing in the 1960s, but there was also a sense that this growth would continue for some time, albeit with some economic sectors growing more slowly than others. In complete contrast, by the time legislation was passed to authorize community health centers in 1975, two new perceptions had come to the fore. First, health care expenditures were growing at a much faster pace than had been anticipated during the 1960s, when Medicare and Medicaid were established as public health insurance to pay for the health care of the poor and aged. Second, it came to be recognized that the U.S. economy could not expand unabated forever; it would eventually undergo periodic downturns or corrections.

The next stage of federal funding for community-level health care began in the late 1970s and continues to the present. The Community Health Center program was authorized by congressional legislation in 1975 under section 330 of the Public Health Law and later amended by the Health Center Consolidation Act of 1996. CHCs are required to provide a comprehensive array of primary care services and to serve an established number of users, based on facility size measured by square footage. CHC facilities and programs are administered by the Bureau of Primary Health Care (BPHC) of the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services (DHHS). These organizations are required by statute to provide a comprehensive array of clinical medical services, including the following (Davis and Millman, 1983, p. 127):

- Diagnostic, treatment, consultative, referral, and other services rendered by a physician or a physician extender
- Diagnostic laboratory and radiological services
- Preventive health services, including nutritional assessment, medical social services, well-child care, and immunizations
- Emergency medical services
- Transportation services as required for patient care
- Preventive dental services
- Pharmaceutical services

Currently, the CHC programs are the only federally funded programs designed to provide health services to residents of underserved communities, but CHCs have had to defend this vitally important role. CHCs easily obtained reauthorization in 1978, the second year of the Carter administration, at substantially higher amounts for a three-year period. It may be argued that because CHCs were so well funded, difficulties arose. Two incidents are worthy of mention here. The first major conflict occurred in 1978 between urban and rural factions in the CHC policy networks when rural health advocates sought to acquire greater resources for rural areas.

A second attempt to radically change the CHC program came in 1981 when the Reagan administration reduced spending for many social programs and block-granted a majority of health programs to the states. Health care funding to the states and localities

before the Reagan administration was offered in the form of “categorical” grants, meaning that the funding focused on specific populations or health issues, such as substance abuse, mental health, family planning, or research. Under Reagan, various categorical grants were grouped and given to the states in four major “block” grants intended to cover preventive health, maternal and child health, primary care, and alcohol, drug abuse, and mental health (Williams and Torrens, 1999). Note that block grants are not the only source of federal revenues at the local level. Federal resources for most of the public health functions are channeled to the state and local levels through direct grants from federal agencies such as the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC).

Although Congress successfully rejected efforts during both terms of the Reagan administration to block-grant the CHC program to the states, Congress ceded to the concept of greater state involvement in the CHC program (Sardell, 1988). This meant that local communities interested in establishing a CHC now had to navigate two different layers of bureaucracy, one at the state and another at the federal level. More recently, in 2002, during the second year of the George W. Bush administration, an unsuccessful attempt was made to close the Women’s Health Division of the BPHC, which oversees various CHC programs addressing the health needs of minority women.

Government support for health service delivery to poor and underserved communities was provided through five different grant structures prior to 1996: Migrant and Seasonal Farmworker Health Centers, Community Health Centers, two types of Health Care for the Homeless Health Centers, and Health Care for Residents of Public Housing. The Health Center Consolidation Act of 1996 brought all these different grant structures into one grant program that is now referred to as the U.S. Public Health Service (PHS) Community Health Center Program. Table 1.1 shows the original grant numbers for these programs as well as the new ones under the Consolidation Act.

The Consolidation Act has been most beneficial to community clinics that serve more than one type of vulnerable population. Before 1996, communities had to enlist limited resources to complete the lengthy, complicated, and cumbersome federal application for

**Table 1.1. Federal Grant Programs Under the Health Center Consolidation Act of 1996.**

<i>Grant Name</i>	<i>Grant Number Before 1996</i>	<i>Grant Number Since 1996</i>
Migrant and Seasonal Farmworker Health Centers	329	330(g)
Community Health Centers	330	330(e)
Health Care for the Homeless Health Centers	340	330(h)
Health Care for Homeless Children Health Centers	340a	330(h)
Health Centers for Residents of Public Housing	340A	330(l)

each of the populations they served. Since 1996, only one 330 application is needed.

Although there has been an undeniable ebb and flow to the allocation of resources into HRSA and the work of the BPHC, the 330 CHC program has been extremely successful. Its success is attributed to the willingness to design programs that are culturally sensitive to the needs of the communities they serve. This sensitivity has contributed to reductions in infant mortality, hospital admissions, and health care costs for Medicaid patients (Leigh, Jimenez, Lee, and Andrews, 2002). The BPHC provided funding to 670 community and migrant health centers in fiscal year (FY) 2000, along with homeless and public housing programs and funding for new startups of CHCs. Since the start of the Bush administration in 2001, the U.S. Department of Health has undergone massive reorganization, with many former BPHC activities subsumed under HRSA or eliminated outright. Nevertheless, CHCs remain a very strong program. In addition to ongoing expansion and additions to the health center system, appropriations in FY 2002 of \$1.3 billion were increased to \$1.62 billion by FY 2004, an increase of more than \$112 million over FY 2003. Information on the HRSA budget and appropriations, including funding for the Community Health Center Program, can be found at the BPHC Web site (<http://www.hrsa.gov/budget.htm>).

Although the CHC program was designed to be operated by nonprofit community organizations, this is not always the case. Some poor and minority communities have been able to build leadership and power via the federally funded community health center program (Schlesinger, 1988), but the reality is that federal, state, and city decision makers feel a greater degree of comfort in granting 330 funding to a partnership between municipal or voluntary hospitals and nonprofit community-based organizations. This provides federal agencies with a greater measure of security based on the fiscal management “expertise” of hospitals compared to new and untried community groups. At the same time, this arrangement also provides hospitals with an additional source of revenue.

Therefore, when a not-for-profit community-based organization seeks federal funding to operate a 330 facility, it is usually instructed to partner with a local hospital. In a majority of cases, the hospital is ultimately the entity that contracts with the DHHS to provide health services, manages the 330 funding, provides the physicians and the medical oversight, and bills and collects from Medicare, Medicaid, and any third-party commercial payers.

In essence, the CBHO serves more as a sponsor by lending its name and credibility in the community, and in some unusual instances, a resident leader may obtain a seat on the governing board of the parent hospital or health center network. These restrictions greatly inhibit the ability of many community-based organizations to develop freestanding CHCs without partnering with a hospital or large mainstream agency with ties to federal, state, and city health policy and decision makers. On occasion, equitable partnerships between communities and large health care entities can be negotiated. Their success depends on development of an organizational framework for those partnerships that will support the growth and sustainability of the partnering CBHOs to respond to community health needs.

### **Organizational Framework: The Development and Growth of CBHOs**

Although by their very nature, CBHOs are a response to local health needs, the federal programs discussed in the preceding section have

been providing health care services at the local level for more than thirty years. These national policy decisions were eventually coupled with state-level policies to provide support for health services at the neighborhood or community level. More recently, because of increasing demographic diversity in the United States, small steps are being taken by federal health agencies to focus on specific populations for targeted health services based on levels of need. Unquestionably, these policies represent a significant level of long-term recognition of the need for community-based health service delivery. These federal and state efforts notwithstanding, the fact remains that health care for the poor in the United States has traditionally been the responsibility of government at the local level.

### The Case for Development of CBHOS

City-level departments of health and other local authorities are cognizant of the need to address neighborhood or community health needs. However, they operate as part of city or local governments, where efforts to maintain or increase the budget for safety and protective services such as police and firefighters have higher priority and wider appeal than health care for the poor and uninsured. Unfortunately, because funding is not infinite, this often means that these governments are caught in a bind with regard to achieving their mission to provide ambulatory or primary preventive care services for their poor and uninsured residents.

In the depressed fiscal environment of the mid-1970s, most cities were forced to cut budgets in almost every area and did so relentlessly in the area of health care for the poor. As an alternative, local governments sometimes encouraged development of local community health centers initially funded under the authority of section 330 of the Public Health Law and later amended by the Health Center Consolidation Act. The BPHC Web site indicates that in 1979, there were 190 community health centers in urban areas around the country that were federally funded 330 centers, and as of FY 2000, there were 670. Though the number of CHCs has certainly grown, it is important to note that CBOs interested in providing health services to meet the needs of their communities have not always been able to qualify for CHC funding.

## Origins of CBHOs

Many CBHOs grow out of the civic and political efforts of community groups and leaders. How these groups and individuals manage to develop their CBHOs is by first establishing political alliances with their elected officials and partnerships with existing health providers such as hospitals or health center networks. Through their relationships in the community, these groups and individuals tend to develop organizations that initially start out as social support agencies that provide health outreach and education while advocating for the poor, uninsured, underinsured, and immigrants and connecting them to available health services. Some of these CBHOs eventually go on to become federally funded CHCs.

Essentially, the economic, political, and social climate of the period from the 1950s to the 1980s in the United States and around the world gave rise to CBHOs. During this time, the United States experienced a convulsion from the ultraconservatism prevalent after World War II and the 1950s to the liberalism of the 1960s, followed by a return to conservatism with the election of President Nixon in 1969. Nixon started the process of unraveling the War on Poverty program, developed to combat economic deprivations long endured by the poor, on two fronts: through federal cuts in social spending and through tax policies, which further enriched individuals in the top 10 percent income group throughout the world.

This same thirty-year period also saw increasing interest around the world and among some groups in the United States in a radically different model of health service delivery that relied on primary care, health promotion, and disease prevention rather than on hospital-based care. To a large extent, this interest was being spurred by the World Health Organization (WHO) as part of its global vision to achieve “health care for all” by 2000. In an effort to realize this vision, WHO convened a worldwide health conference in Alma Ata in 1978. Delegates from 134 nations gathered at the conference and agreed, on behalf of their countries, to focus on primary care as the major strategy for health care delivery, increase community participation in health care planning, and make health care more accessible for everyone than it had been in the past. Only later did it become clear that while delegates from the United States and several other countries were pledging to support the provisions of Alma Ata, their increas-

ingly conservative governments were busy cutting even deeper into health care spending for the poor and uninsured.

In the midst of this worldwide, unreceptive political and economic climate, Sidney and Emily Kark and their colleagues seized a small window of opportunity, opened briefly by the apartheid government, and began to develop health centers in South Africa in the mid-1950s, based on the principles of community-oriented primary care. The civil rights movement, with its principles of community empowerment and political and economic equity that later led to the War on Poverty, opened a much bigger window in the United States in the 1960s, which Dr. John Hatch and his colleagues used to pioneer the development of CBHOs, based on the model of the black church. The North Bolivar County Health Council (NBCHC) in Bolivar county in the Mississippi Delta developed the first group of community health center–affiliated CBHOs, which were chartered as a community development corporation. Today NBCHC owns and operates the Delta Health Center in Mississippi and the North Bolivar County Farm Cooperative, among other health centers. During the 1960s and early 1970s, Eugenia Eng and Theodore Parrish were among some of Dr. Hatch’s colleagues who assisted in the pioneering work of developing the early CBHOs in urban and rural African American communities in the United States (Geiger, 2002; Hatch and Eng, 1984; Hatch, 1969).

## Growth of CBHOs

The United States of the 1980s was politically conservative, and it was clear that few provisions would be made to care for the health of the poor. Given the tone of that environment, it is understandable that the development of community-based health organizations, with or without federal funding, was inevitable. Although some CBHOs are indeed federally funded 330 programs, based on the definition provided earlier, some may not provide primary care or clinical services. Those CBHOs are eligible for various types of support from local and state governments to provide a broad range of health, mental health, and health-related care, including social and support services. They also qualify for state or federal categorical grants, many of which are used to provide specialty services, such as outreach and education for maternal child health, HIV/

AIDS, and other health-related nonclinical services, targeting distinct subgroups, which varies tremendously among these clinics.

Since the late 1970s, there has been steady growth of CBOs in the United States. There may now be more than one million of them in the country; the exact number is unknown. What is known is that significant numbers of them have been established with the mission to focus exclusively on health or health-related issues. The very development of increasing numbers of CBOs and CBHOs—some of them organized by newly arrived immigrant groups, communities of color, or poor to middle-income communities and many of them established to meet health and other basic needs—at this particular juncture in U.S. history is significant, for three reasons. First, we know that the development of organizations by any group of people for the purpose of addressing their specific concerns is indicative of a structural failure by the larger society to respond to those needs (Bayne Smith, 1996a). Second, the capacity to build organizations is a sign of political maturity and readiness on the part of the organizing groups to negotiate with mainstream groups from a position of power. Third and most important is the willingness of many of the new community-based organizations to function as instruments of social change in a diverse and multicultural society (Bayne Smith, 1996a).

During the past thirty years, there has been an increase in the number of not only federally funded CHCs but also CBHOs. CBHOs tend to be nonprofit organizations that are developed with or without federal funding and established as independent clinics or community-based organizations. CBHOs developed more recently than the CHCs, often as a result of dissatisfaction with the cost, quality, or cultural insensitivity of local public and private health care providers. Eventually, some CBHOs move to become federally funded 330 clinics, but some retain their independence out of a belief that they provide a necessary alternative mode of service delivery (Davis and Millman, 1983).

## Health Services and the Nonprofit Sector

A 2002 study of nonprofit organizations and services in New York City's neighborhoods, by Wolpert and Seley, indicates that in 1989, there were approximately 20,000 nonprofits in the city. As of May 2000, there were 27,474 registered nonprofits, of which 9,078 were

reporting public charities that file annual reports to the IRS. The other 18,196 nonprofits were amalgams of private foundations, religious organizations, large specialized organizations, and other entities. This study is significant because New York City has the largest and most diverse concentration of nonprofits of any city in the nation and provides an opportunity to look at the full spectrum of nonprofits, by sector, from small mutual benefit organizations to the operational headquarters of international organizations such as the International Rescue Committee and Planned Parenthood. The Wolpert and Seley study provides data on all organizations in the health sector in New York City, including large hospitals. This information is especially important in explaining the growth of CBHOs, for several reasons:

- Though not the largest in terms of number of organizations, health is the most heavily funded of all the nonprofit sectors.
- The health sector provides a higher percentage (85 percent) of full-time employment than any other sector.
- Nonprofit expenditures in New York City totaled approximately \$40 billion in 2000, of which \$20 billion was in the health sector.
- The greatest increases in New York City health services in the years 2000–2002 were in terms of age for children and teens and in terms of ethnicity for Hispanics.

### Distinctions Between CBHOs and CHCs

CBHOs and CHCs are more different than they are similar. The similarity of CBHOs and the federally funded CHCs begins and ends with the fact that they are both focused on primary rather than acute or institutional care. Over the course of the past century, as we moved from the old dispensaries to the current migrant and community health centers, the Western biomedical model has provided the organizational framework for service delivery. This linear model has consistently delivered technological advances in medical care. Subsequent to the Flexner Report that led to the reorganization and redirection of the biomedical model, it became and remains today the driving engine of the entire U.S. health care industry. As such, it has enjoyed hegemonic status for nearly a century. Needless to say, it is also the most powerful force behind the

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**Exhibit 1.1. Linear Flow of CHCs and the Biomedical Model.**

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Policymakers and health professionals often use a top-down, linear approach in which decision making regarding design and implementation of services is focused at the highest professional levels and usually does not include community input. Within that linear decision making model, decisions tend to be made in the following order:

1. Facility size
  2. Number of clinics
  3. Structure of operations
  4. Staffing levels
  5. Percentage of insured and uninsured to be served
  6. Type and frequency of clinic programs and sessions to be offered
  7. Hours of operation
  8. Service modality: disease diagnosis and treatment
- 

organization and operation of government-funded CHCs as depicted in Exhibit 1.1.

In contrast, the development, organization, and operation of CBHOs start out not from the dictates of the industry but as a response to health needs of the community. A major distinguishing characteristic of CBHOs, compared to CHCs, is that they strive to deliver a more holistic set of services based on the biopsychosocial health care model. In this approach, CBHOs tend to plan and deliver services using a more resident-responsive, if not resident-led, approach that pays careful attention to the whole individual, including cultural and community influences. This model, though effective, does not receive the full support it needs from government or private funders, who tend to focus more on specific health issues or specific populations with health problems rather than addressing the underlying causes. Another important distinction is that unlike CHCs, not all CBHOs provide primary care services. When the CBHO delivers primary care or when the CBHO is also a CHC, a medical director is of course required, but often a significant level of service is provided by nurse practitioners or physician assistants.

Probably the most distinguishing difference between CHCs and CBHOs comes from the recognition by CBHOs that health care services to vulnerable populations such as the rural or urban poor and underserved communities must include capacity for outreach and

education. For certain populations, it is first necessary to promote access to and use of services before underserved populations can avail themselves of mainstream health services. Probably the most important distinction that even managed care companies have only recently come to terms with is that it is not effective to offer primary care services to underserved populations facing multiple problems without also offering case management and social support services. Figure 1.1 depicts the essential ingredients that set CBHOs apart from CHC and more mainstream forms of health services delivery.

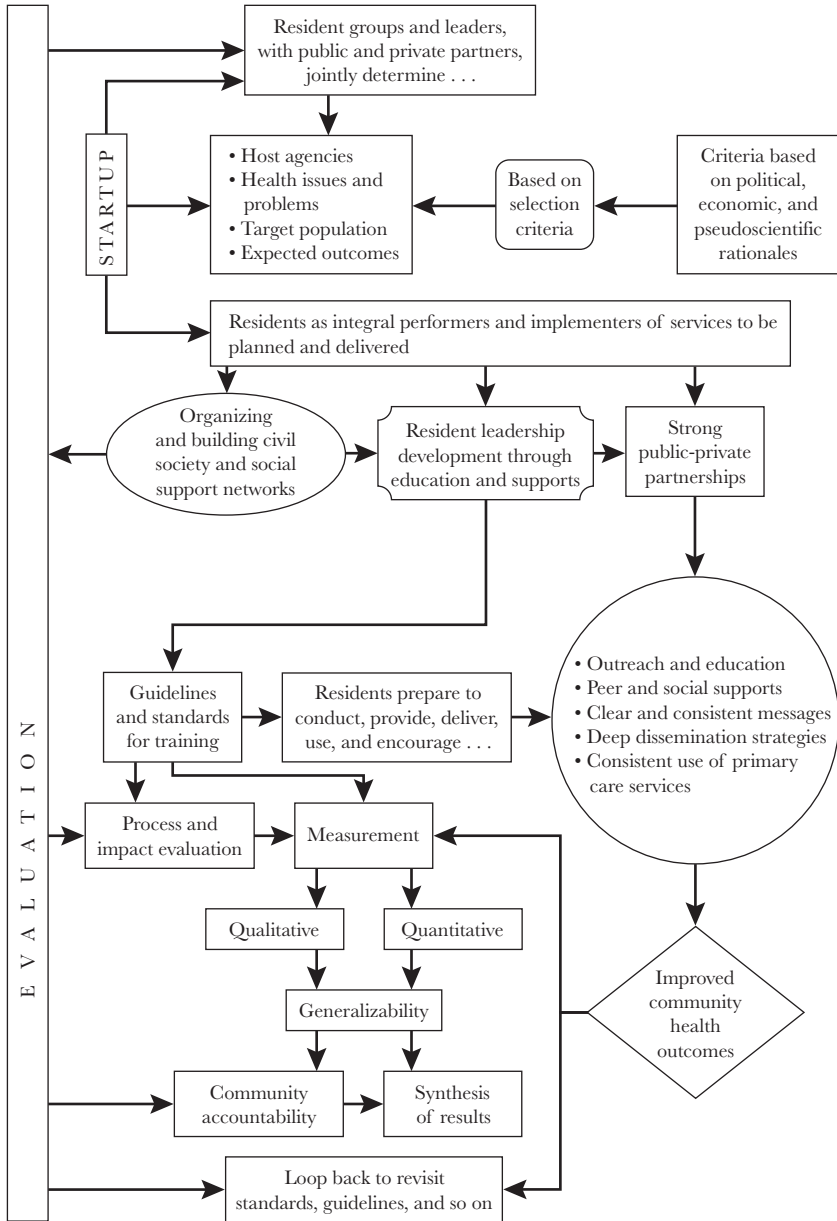
### Creating a Structure for CBHOs

Development of an organizational framework, whether it is for small CBHOs or large for-profit organizations, is best discussed as a series of steps. The first and most important step for any group interested in establishing a CBHO is the development of a clearly thoughtout, long-term vision for the organization. The next step is the preparation of an organizational mission statement. The mission statement is crucial. Everything the organization does must flow from and be in concert with its mission statement, including the organization's goals, objectives, strategies, and espoused values. Once these aspects of the mission are clear and have been precisely articulated, they must then be used to design an organizational structure that will permit the organization to function as a physical entity established to carry out its specific mission.

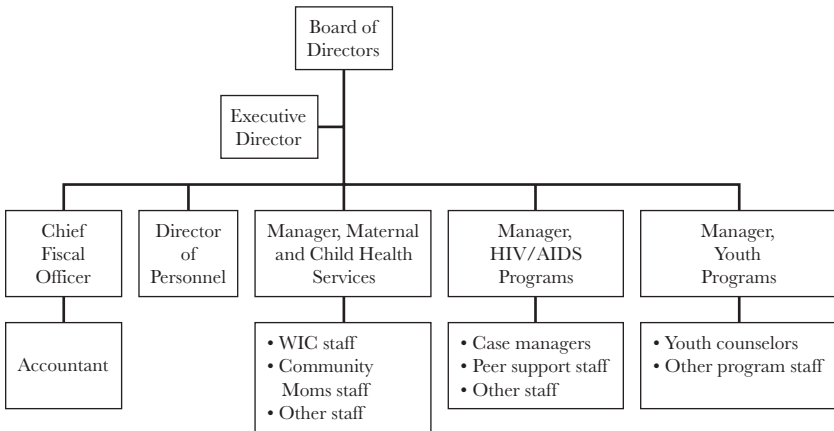
Although the framework and structures of organizations vary, most CBHOs tend to be nonprofits and as such usually have a governance structure in which there is a board of directors with financial and policy oversight (see Figure 1.2 for an example). The executive director position reports to the board of directors or trustees and also makes the day-to-day decisions regarding the operation of the organization, usually with input from the managerial staff. Whether management-level staff are required depends on the size, mission, and budget of the organization; these individuals report to the executive director. Direct line staff and clerical support staff have ongoing hands-on contact and provide direct services to the population being served.

To establish their legal identity, most CBHOs become incorporated as a not-for-profit entity and thereby obtain tax-exempt status.

**Figure 1.1. Community Health Partnerships:  
Collective, Resident-Responsive Decision Making.**



**Figure 1.2. Organizational Governance Structure**



In most instances, these steps are also prerequisites for attracting public or private funds. Funding sources are reluctant to contribute to unincorporated entities that are not tax-exempt for reasons of accountability. Nonprofits are required to have boards of directors that are legally required to provide financial oversight as well as policy and managerial oversight in some instances. This structure provides assurances to the community, who in the case of federal 330–funded CBHOs must hold at least 51 percent of the seats on the board, that the community’s voice will be heard and its needs met. It also provides assurances to funders that sound financial and management procedures will be put in place to ensure effective operation of the CBHO.

**Primary Role of CBHOs:  
Responding to Community Health Concerns**

Unlike community clinics, outpatient health centers, or even federally funded CHCs, CBHOs are developed essentially as a response to identified community health concerns. Consequently, as noted earlier, not all CBHOs provide primary care services. The roles and functions CBHOs are designed to fulfill depend on the needs of the community they are founded to serve. As a result, the primary

role of every CBHO is to be fully aware of the health issues and concerns of the community in which it is located and to work toward meeting those needs. As long as the community is well represented at the board level, the CBHO is held accountable to the community it serves.

### Major Functions of CBHOs

As CBHOs seek to carry out their most important function of meeting community health needs, they must simultaneously develop the skills and resources needed to function as strong advocates. Although these two functions are intertwined, it is highly unlikely that a CBHO that does not engage in advocacy will be able to attract the resources needed to provide health services. Advocating for improved health outcomes has to occur on multiple levels, making use of all the modern tools of communication and social action. Health advocacy must ideally start within the community being served, through education for neighborhood residents and information sharing to help the community adopt healthy behaviors. At the same time, advocacy must also extend outward. Some of the more critical external advocacy functions include lobbying policymakers to develop and implement health policy that is beneficial to the community, cultivating relationships with public sources and private philanthropies to obtain required resources to address community health needs, and developing partnerships with other health organizations, from large hospitals to other CBHOs, in order to create and sustain programs and services to improve health outcomes.

### The CBHO Partnership Opportunity

Improved health is a product of social action, not just medical care. Communication and involvement of all sectors of the society are therefore key concepts that must be clearly understood and pragmatically exploited. Whether responding to community health concerns or serving as health advocates, CBHOs are essential partners in the spectrum of health care delivery, and they provide a unique opportunity for partnership with progressive organizations seeking to improve health delivery and consumption and health outcomes for

diverse communities around the country. Mainstream health organizations benefit greatly from partnerships with CBHOs, as the mainstream organizations gain access to new market segments consisting of groups traditionally served by CBHOs. These are groups that mainstream organizations have difficulty reaching outside of urgent or emergent situations. One mutually advantageous partnership would be between CBHOs and the national movement of Physicians for a National Health Program (PNHP), for example. PNHP members are physicians who are active across the spectrum of medical endeavors, from primary care doctors and surgeons to public health specialists, psychiatrists, and administrators who work in hospitals, clinics, private practice, HMOs, and public agencies. The PNHP vision is for a national health program that is federally mandated but administered at the state and local levels. It would be a single-payer public plan covering all medically necessary services from acute to long-term care and prescription drugs. The PNHP plan provided in partnership with CBHOs using a combination of Western medicine and delivered in culturally acceptable formats would provide the United States with a strategy for eliminating health disparities. At the very least, partnerships between CBHOs and local PNHP groups hold promise for joint advocacy efforts to improve community health outcomes.

## Key Points

- Higher mortality and morbidity from treatable and preventable diseases are concentrated among people of color because in the United States, a much higher percentage of nonwhite residents than white residents live in poverty.
- Government support for health care for the poor and the uninsured is a political minefield in which the ebb and flow of resources depends to a large extent on the amount of political advocacy being done by interest groups, policy networks, and other interlocutors at different historical periods. The response from poor and immigrant communities across the country has been a large increase in CBHOs developed by and in partnership with community residents. These CBHOs seek to address health issues identified by residents, with programs and methods designed with resident input.

- The development of resident-led CBHOs in the past two decades is a direct outcome of the socioeconomic and political climate in the United States in which the larger society failed to respond to the health needs of immigrants and the poor. Therefore, marginalized groups had to develop the political maturity to advocate on their own behalf and to function as instruments of social change.
- Policy options with a greater likelihood of eliminating health disparities are unlikely to come from traditional health professionals and their organizations or from the usual policymakers.

## Study Questions

1. Historically, how has health care policy developed in the United States, and what aspects of the current health care system continue to foster the development of CBHOs?
2. Trace the evolution of community health care from dispensaries to CHCs and CBHOs. Then, based on the distinctions between CHCs and CBHOs, identify which of these entities would work best in your community.
3. What are some effective strategies that CBHOs should put in place to meet the health needs of their communities?

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