Editorial: NEIGHBORHOOD HEALTH CENTERS

The rise of neighborhood health centers in the 1960's was a direct result of pressure from the Office of Economic Opportunity (OEO) and the US Public Health Service. The typical center is built around a set of family oriented services, based on a compact geographic community, and usually connected in some way with a back-up hospital.

Health Centers Are Not New

Historically, neighborhood health centers are not new. Between 1910 and World War II a number of health centers developed in the United States, mainly in the immigrant ghettos of large cities. They were spurred by social and health care reformers, often based in the settlement houses, who sought to bring public health measures, such as prenatal care and tuberculosis control, to given communities. They emphasized decentralized, local coordination of previously fragmented public and private services.

With the exception of venereal disease and tuberculosis, this early movement left the field of curative medicine to the private practitioner. Also, despite lip service to the contrary, it seldom engaged seriously in organizing community residents. These inherent shortcomings contributed to the decline of the movement. Externally, doctors and some local officials fought decentralized neighborhood services. Then, as the federal government took increasing responsibility for welfare in the 1930's, the private social agencies, once the sparkplug of the health center movement, turned away from social concerns to focus on individual casework.

Health Centers Reborn

The second wave of neighborhood health centers in the 1960's took place at a time when hospital outpatient departments (OPDs) were becoming for inner city residents the major source of health care. OPDs were underfinanced and organized primarily for the purposes of medical teaching and research, not patient care. OEO reformers decided the new centers were to be placed in poor, mostly Black communities. They hoped to provide neighborhood services while promoting structural changes in the health institutions serving the poor. But no serious commitment to do either existed in the major leadership of Congress or the Executive Department. And ironically, most of these health centers in the neighborhoods were actually dependent for sponsorship and funding on the very institutions which were to be reformed.

In the upsurge of the health care reform movement, students and professionals in medicine, nursing, dentistry, social work, health care administration and the like, looked to the neighborhood health centers to solve their own dilemmas of personal and professional relevance. Some left the universities and teaching hospitals to work in the ghettos because they felt alienated from the competitive and hierarchy-bound atmosphere of those institutions. Others left that environment because they thought a decentralized health system based in communities could deliver better care. Many really believed the health care millenium was about to arrive.
What has happened as a result of the neighborhood health center movement? Some 200 centers have come into varying degrees of existence. Most are in urban or rural slums. The early promise that they would spearhead a massive federal commitment for health care reform has turned sour, a victim both of the Vietnam War and the shuck of the War on Poverty. The neighborhood health centers are but a grain of sand in the sea of effort needed to provide decent health care for poor communities.

Models for Change

There are two ways to assess the health centers' impact. We can look at them as a technical model of health care and consider what they have taught us about the delivery of quality care; how health care team relationships are worked out; the relation of the center to a backup hospital on the one hand, and to the community served on the other. Questions can be raised about their efficacy as a focus for family health care and community health services, as well as their "cost/benefit ratio" when the average visit costs over $30. Neighborhood health centers offer many important lessons. But this should not overshadow the fact that true decentralization of health services was never given a real try.

These technical questions are not our concern at the moment. Rather, our concern is with the health centers as a political model for reform of services in the modern ghettos. Many in the 1960's thought the centers could become the locus for general community change. Most of those who thought so were white reformers who did not live in the communities concerned. Black and Third World professionals, usually in private practice in these same communities, were almost totally bypassed in the planners' considerations. And by and large, the communities themselves were not consulted.

Too Little Too Late

The general consensus today is that the health centers have not catalyzed community change. They have been too little and too late. As jobs disappear and dope increases in most urban poor communities, the possibility of a health center becoming a major focus for change becomes as grim a joke as phrases like "urban renewal" and "war on poverty."

Another question we can ask is whether the health centers have led to significant reform of the university medical schools and big teaching and voluntary hospitals associated with them. Here again the record is largely negative, but then little effort was ever mounted toward this goal. These institutions have shown themselves far more intractable and resistant than reformers believed six or eight years ago.

Perhaps neighborhood health centers were never designed as models of technical or political change. By dangling federal money on federal strings in front of poor communities, with glib rhetoric of maximum feasible participation of the poor and of community control, a scramble was encouraged which set neighbor against neighbor and community against community. Soon the internal war within communities to secure antipoverty money far eclipsed in zeal the energy of the poverty warriors in Washington. Communities found themselves fragmented and exhausted in the fight over the crumbs. When people were fighting among themselves, they could not see the real enemy.

Today the neighborhood health center is no longer the fashionable rallying cry it once was. The new term is "HMO" or Health Maintenance Organization. Washington is making every effort to sell the notion of HMO's to neighborhood health care centers. It seems likely that the HMO would take away much of the present and potential power of the community. Stripped of its Nixonian public relations cover, the HMO is a vehicle for corporate managers to move into control of health care (see BULLETIN, December, 1971).

NENA

The example of the NENA Health Center in New York's Lower East Side, discussed in this issue, shows the enormous social energy that has gone into the creation and maintenance of this island of health services. Unlike many of the country's other health centers, NENA grew out of community concern and effort. It has had its share of power struggles and disappointments. But its basic problem lies in its lack of resources—money, staff and facilities—to do the massive job it has undertaken. For that, the responsibility lies not in the Lower East Side, but in the network of political and professional power that stretches from Washington to the medical centers and hospitals ringing the community. And while neighborhood health centers such as NENA can offer important services, that power and those resources still wait to be challenged.
NENA: COMMUNITY CONTROL IN A BIND

Des Callan, co-author of the following article was associate director, then director, at NENA Health Center from Sept., 1968 till Nov., 1970. For the last year he has been a Health PAC staff member.

NENA, short for North East Neighborhoods Association, in the northeast corner of New York’s Lower East Side, runs one of the few, if not the only community initiated, community controlled neighborhood health centers in the United States that has received major federal financing. Now rounding out its third year of operation, NENA illustrates some of the strengths and limitations of the neighborhood health center movement of the 1960’s, and of the community control impetus within it.

NENA has been caught in a series of binds, basically not of its own making, that have often set one sector of the Health Center against another. The Center has been unable so far to wrest from Washington and the outside health establishment the resources needed to do the job NENA promised its community when it set out in 1968. Instead, the NENA story is primarily one of the heavy expenditure of energy keeping the Health Center afloat while trying to deliver even a portion of the services its patients require.

Situated on East Third Street near Avenue C, the Center is open to all persons, regardless of income, who live in its designated district. Once an immigrant slum ghetto of Jews, Italians, Ukrainians and Russians, in the last generation NENA’s area has become primarily Puerto Rican, with a sizable number of Blacks and a small minority of whites, mostly elderly Jews and a scattering of hippies and ex-hippies. A small number of businessmen, artists and teachers live in renovated brownstones or the one middle income housing project amid the mass of decaying tenements and low income projects.

Community Struggle for a Health Center

NENA’S Health Center developed as a result of several bitter “learning experiences” of Lower East Side residents in the middle 1960’s. The first of these occurred in the winter of 1966 during the transit workers’ strike. Normal bus service in the Lower East Side is very poor, and cabs are virtually unavailable. But with the transit strike, “Lower East Side residents found themselves cut off from medical care,” said Ms. Wanda Moore, present co-chairwoman of the Health Committee of the NENA community board. “Bellevue was the only source of general medical care. But with city buses shut down by the strike, Bellevue was truly inaccessible.” Under these conditions, ordinarily treat-
able illnesses become life-threatening emergencies.

One snowy evening, a child on Sixth Street developed an acute asthmatic attack. Treatment was delayed and the child developed more and more difficulty breathing. Several hours and many frantic phone calls later, the critically-ill child was finally brought in a neighbor's car to Bellevue, the huge city hospital two miles away.

"People were really angry," said Ms. Moore. This experience of near-death because of lack of transportation was not an isolated incident. The problem oppressed everyone. "They wanted a health center right in the neighborhood. So they turned to NENA for help." In particular, the Sixth Street Mothers, a neighborhood block group, turned their attention to health and to NENA.

NENA was established to coordinate groups around community issues. In 1966, NENA had committees to deal with housing, education, narcotics addiction, law enforcement and transportation. But it was not until the Sixth Street Mothers presented their case to NENA that a committee on health was formed. And, in truth, it was health that put NENA on the map.

At the same time, independent of the community's activities, medical students, interns and residents at Bellevue became disgruntled with the health care offered there. They petitioned New York University Medical School, which provides the professional services to Bellevue, to create satellite health centers in the surrounding community.

In the spring of 1966, the Health Committee and the dissident doctors met together and planned a strategy to encourage the medical school to establish a health center in the NENA area. First the Health Committee met to begin planning for a proposed health center in the Lower East Side community. Then these plans were presented to Dean Lewis Thomas of NYU. He assigned faculty members to help refine the Health Committee's plans into a formal planning proposal. Over the next year the Health Committee consulted with many community groups, storefront agencies and service workers to draw up its component of the plan. In March, the plan was handed over to the medical school for submission to a foundation.

Two months later the Health Committee was shocked to learn that NYU had decided not to submit the proposal, the product of a whole year's work. The Health Committee charged NYU's medical dean with bad faith, and broke off negotiations with the NYU-Bellevue Medical Center.

The NENA Health Committee found itself back at the beginning, older but wiser. They had learned an important lesson: don't rely on major medical centers for help. And so the Health Committee began to plot a course which would avoid dependence on either Bellevue or Beth Israel Hospital, which together provide a major portion of health care on the Lower East Side.

During the summer of 1967 the Health Committee went to Washington. By judicious use of their Congressman, they got a consultant from the Office of Economic Opportunity (OEO) to advise them on starting a center. Soon thereafter, the group realized it could not live with two restrictions imposed by OEO grants: first, the grant had to be administered by a medical organization such as a medical school or center. The Committee wanted federal money to go directly to their own community organization. Second, OEO grants could only be used to provide care for the poor. The Health Committee did not want to restrict the use of the health center by income. It was to be a neighborhood-wide facility for all to use.

The Health Committee was unclear about what course to take. But whatever the course, it was clear that an arrangement with a back-up hospital was necessary. At the consultant's suggestion, the Health Committee had approached New York Infirmary, a small acute care hospital, in the fall of 1967. The relationship offered important things to both parties. The Infirmary, which was applying for permission to expand, felt that its association with NENA would demonstrate its need for more beds, as well as meet criteria for community service. For NENA, the arrangement would permit future health center doctors to admit individuals to the Infirmary as their private patients, providing continuity of care. Moreover, it set up

"People in the neighborhood first said, 'You're never going to get anything.' But we didn't give up."

—Wanda Moore
Co-chairwoman of
NENA Health Committee
a relationship of equality with a community hospital which was better adapted to the needs of NENA's future patients. Realizing the limitations with OEO, the Health Committee sought other alternatives. Another Washington adviser told them of the availability of Public Health Service funds for health centers, under less onerous guidelines.

During the winter and spring of 1968, a flurry of activity ensued to prepare a grant application. Negotiations with the Infirmary were sped up. A core administrative and medical staff was recruited. And a temporary building was acquired to house the center until larger quarters could be built.

By summer, 1968, NENA's health center had been funded. Fifteen months later, in September, 1969, the Center opened its doors in a small renovated building that formerly housed a boys' club and before that a hotel for alcoholics. The structure was but 21 feet wide and five stories tall. It had no elevator.

**NENA Today**

Today, the NENA Health Center is located in this same tiny building. It has 35,000 registered patients and a staff of about 125; 250 patients walk through its doors each day. Services available include general family care; some medical specialty services including surgical consultation, dermatology, obstetrics and gynecology, ophthalmology and ear, nose and throat; dentistry; pharmacy; laboratory; X-ray; limited social services; and in a separate storefront, a city-sponsored detoxification program for addicts. There is also a child care program for patients waiting to be seen at the center.

NENA offers comprehensive, continuous care, both preventive and curative, to a few thousand enrolled families, who are seen by a health team, primarily by appointment. It also offers drop-in or screening care, including emergencies, available without appointment eleven hours-a-day to all registrants, whether enrolled with a team or not. In fact, because of the demand and the limits of time and space, enrollment with the health care teams is generally not open to new families.

The Center's small building limits NENA's ability to deliver efficient and courteous care. For instance, three family health care teams (each composed of two physicians, a nurse practitioner, medical assistant, community health worker and secretary) use the five rooms on the second floor. The teams have to alternate sessions and reduce office hours because of the lack of space. The result is that the Center can offer the team approach to relatively few families.

Scores of daily drop-in patients who are not enrolled in the teams are seen in three small examining rooms at the back of the long, narrow first floor. These rooms are also used by visiting specialists. On the first floor, there is only one waiting room. Patients waiting for the laboratory, X-ray, the pharmacy and a visit to the specialist must all wait in the same tiny area.

The third floor of the Center contains three modern dental chairs with three full-time dentists and an equal number of dental assistants. The dental unit is not yet integrated into the health team structure.

The Center's fourth floor houses the administrative and personnel offices. The Health Committee of the NENA Board has its offices around the corner from the Health Center in the community organization's headquarters.

Two major groups have shaped NENA's development over the three-year existence of the Health Center: the Health Committee and the staff. Both groups have contributed their share to the accomplishments, problems and contradictions that have emerged over this period.

**The Health Committee**

By 1969, when NENA opened its doors, the Health Committee had boiled down to twelve active members. Though the Sixth Street Mothers were still represented on the Committee, several other groups had gained prominence. One of the most powerful of these was a small group, mostly white, which was associated with the local Reform Democratic Club. The ascendence of this particular group on the Committee is no surprise, considering the selection process.

The Health Committee maintains that it

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**NENA's dilemma:**

"It's either an increasingly thin bandaid for everyone, or continuous medical care for a limited number of people."

—A NENA Physician
is open to anyone who lives and works in the community. However, the selection process narrows this down considerably. Health Committee members are selected in a two-stage process: first, prospective members must join a subcommittee. If their work is deemed worthwhile by the subcommittee chair-person, nomination for membership on the Health Committee may be made. Then the entire Health Committee votes on the candidate.

This process was developed to encourage participation by new people who really had an interest in health. As Ms. Bertha Dixon, present co-chairwoman of the Health Committee said: "The problem with community-wide elections is that the same old politicos who have organized their faction get elected. Often they aren't truly representative and aren't really interested in health."

Unwittingly, however, the Health Committee's selection process more closely resembles the trustee model of the private, voluntary hospital than a community-accountable and patient-responsive model. Like a hospital board of trustees, the Health Committee is a self-perpetuating body, which elects its own successors and has, in effect, an unlimited term of office. While a monetary contribution is not a criterion for Health Committee selection, as it is for many hospital boards of trustees, the requirement of a time and effort contribution to a subcommittee may function in similar ways. Once on the Committee, verbal skills and endurance limit effective participation even further. These reasons explain, in part, the former prominence of white, basically middle-class, Reform Dems on the Committee.

On the Defense—Until NENA was funded, the Health Committee had actually been on the offensive. The Committee spearheaded plans for a new health center. Thereby it had taken on NYU Bellevue, which lay outside the community.

After being funded in 1968, however, the Health Committee increasingly assumed a defensive posture with respect to the community and even its own hired administrators. Executive sessions of the Health Committee, closed to the community and the Center's administration, began to abound. "It got to a point," said one Committee member, "where we couldn't meet at the Health Center or the NENA offices and had to meet in members' apartments." The Health Committee abandoned its focus on planning for new programs and a new building, while getting caught up in the day-to-day administration of the Center.

Two examples illustrate the destructive tendencies fostered by this defensive posture. The first had to do with building the new Health Center. It was clear from the first day that NENA acquired its temporary quarters on East Third Street, that a new Health Center was imperative. One logical site was a playground that had been purchased with the temporary building. The only difficulty was that the community had recently liberated the playground from its previous owners, who had strictly forbidden local block children from playing there. In other words, the playground had become a cause celebre among block residents, who now feared that NENA would destroy their hard-won victory.

Rather than deal with this challenge head-on, the Health Committee avoided the issue. For some months, many of its members wouldn't even walk down Third Street for fear of meeting the local antagonists. Just this year, the Health Committee's representatives failed to show up at a crucial community meeting that dealt with the site for the new building. The Health Center administrator was left alone to face the opposition. The avoidance of these issues has cost the Center valuable lead time in pursuing plans for a sorely needed new building.

A second example of the problems caused by the Health Committee's defensiveness arose around its assumption of administrative prerogative. At NENA, for instance, not only must the project director and all professional staff (including doctors) be interviewed and approved by the Health Committee, but also all other staff that deal with the public, from security guards to dental assistants. While the administration agreed to this policy, it is clear that it took an enormous effort on the part of the Health Committee to accomplish this task when the Center was being set up. Such effort might have been directed toward evaluation of existing programs, planning new ones, moving on the building or the Health Committee's one-time role of militant spokesman on health affairs for the community at nearby hospitals.

But the Health Committee's inward orientation became clear when several Health Committee members insisted that two employees be fired primarily because they had insulted the Health Committee. The employees had gotten into an altercation with several Health Committee members when they tried to attend a closed executive session of the Health Committee. But, the issue is whether it is wise for the Health Committee to become so entangled in such detailed administrative matters to the neglect of larger policy matters. Ulti-
mately, the case of the two employees was brought to an arbitrator where it presently rests unresolved.

Community Accountability—It is clear that the NENA Health Committee had some real degree of control over the Center. Why did it become defensive?

With respect to the community, such as the residents of East Third Street, the Health Committee had a reason to be defensive. Since its selection process made the Health Committee accountable neither to the patients that used the Center, nor to the larger community, the Health Committee found it difficult to be open with opposition forces within the community.

Had the Health Committee felt confident about a community-accountable base, it could have acted in a much broader role as sponsor of the Health Center. It could have stimulated community dialogue; written reports for all the community to read; published a newsletter and even held public hearings. It could have put the heat on Bellevue, NYU and Beth Israel to improve services to the Lower East Side and to develop mechanisms for accountability to patients.

It seems the Health Committee veered

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NENA's Original Goals

1. Good health services should be available to all people regardless of economic or social class.

2. Health Services should be available right in the community where they are needed, so that local people need not have the extra expense and inconvenience of traveling to overcrowded hospitals.

3. A good outpatient clinic should be an integral part of community life to serve the people just as schools, churches, social agencies and settlement houses do.

4. The facility should be community oriented; and neighborhood people should have a voice in the way that it is run, in order that it serves their particular needs, and so that they can feel that it really belongs to them.

5. The facility will be run by a Board of Directors consisting of community representatives which should meet regularly to discuss problems and to consider new ideas that come directly from the community. The Board can also serve as a liaison committee between the community and established city agencies.

6. Clinic facilities should be modern, pleasant and have a cheerful welcoming atmosphere.

7. Only professional staff of high quality should practice in the clinic. All doctors should have finished their residency and be familiar with the type of patient and clinic they will be serving.

8. Utilizing team delivery of health care each family would continually see the same doctor. This will inspire more confidence on the part of the patient and establish better rapport between patient and doctor. This will also enable the doctor to know his patient and the patient's family. It will save unnecessary duplication of tests, repetition of visits, conflicting instructions, time and money. But most important, it will ensure continuity of care.

9. Courtesy and real concern for the patient as a whole person should be a "Must" on the part of the staff.

10. An appointment system should be worked out so that patients do not have long waits to get assistance, and thus large waiting rooms will not be required.

11. Besides professional staff, neighborhood people be hired to work in as many capacities as they can be trained to fill and employment should be based on ability to do the job, and not on educational standards alone.

12. Because of the systematic exclusion of Puerto Ricans and Negroes from the professions, as many of these people as possible should be hired in the Health Center at all levels.

—October, 1967
in the direction of administrative decision-making because it felt that administrative control meant real control. It is apparent that the Health Committee had deep suspicions of the professional staff it hired. It felt somewhat insecure about its role. In part, this was unavoidable when the Health Committee, which had previously been a planning body alone, became an employer of a staff assigned with the task of organizing and operating the new Health Center. It thereby created a new center of power and decision making besides the Health Committee itself. And it wasn’t certain that the professional staff shared its agenda.

One other element, peculiar to NENA, complicated this chemistry. Since 1965, NENA had a professional community organizer, who had provided expert assistance throughout the struggle to get funding for the Health Center. Shortly after the new professional staff arrived, this organizer left NENA. The effect on the Health Committee was profound. It had lost its trusted counselor precisely at the time that it needed one. Unfortunately, none of the professional staff could substitute in this role. The result was heightened insecurity on the part of the Health Committee and increased distrust of the professional staff.

"The problem with the Health Committee is that it cannot use or include strong people oriented toward community control, because of insecurity about its base in the community."
—Ernesto Martinez
Coalition for Human Housing

Recent Changes—Over the three years of the Health Center’s life, the Health Committee has been challenged only sporadically by community and worker forces. But these struggles have brought about some changes. There has been a marked decrease in secrecy of meetings, with fewer closed executive sessions. The participation of representatives of the Center’s staff has been encouraged. In addition, the Health Committee seems to be refocusing its attention on long-term programs rather than on the day-to-day operation of the Center. Such long-term plans include the building of a new center, proposals for a mental health program and the creation of a patient advocacy program responsible to the Health Committee itself. But, not until the Health Committee deals with its lack of accountability to patients who use the Center, will it be able to overcome some of its intrinsic weaknesses.

**The NENA Staff**

Of the approximately 125 NENA Health Center staff, some three-quarters are non-professional. By a strict policy of the Health Committee, enforced by the administration, all these workers must come from the surrounding community. They are primarily Puerto Rican and Black, with a very few whites. Since the Health Center is known as a community institution, it has particularly attracted to its work force persons who are conscious of their place and stake in this community. It is a work force which is tied in a hundred ways to its community, through extended families, gossip, rumor, block loyalties, political and social clubs. Most of the workers are people who would rather not leave the neighborhood to work in the outside economy, but who would prefer to work close to home.

It is not a work force of political activists. One nurse characterized the staff as a whole as "very conservative. Very few are progressive. People are very easily satisfied with a small raise. Most of them don’t feel secure." Another nurse said she had often been told by non-professional workers: "Well, you’re a nurse. You can work anywhere. But where can I go?" This shows a pervasive fear of job loss among many on the staff. Despite brief periods when fear of dismissal has had some basis in reality, the fact is that turnover among staff, from either firing or quitting, has been exceptionally low.

Administrators claim that it is almost impossible to have someone fired at NENA regardless of the reason. The ostensible reason lies in the existence of an extensive grievance procedure. Behind this lies the reluctance of the administration and Board to stand up to countercharges of professional and administrative bias against a community resident who can mobilize local and even Board opinion on his or her behalf.

Thus there is felt job insecurity on the one hand and actual, at least short-range, job security on the other. The explanation of this fear would appear to lie in the uncertainty of many staff members about the true permanence of the NENA Health Center. For many, this is their first good
job. They fear their experience, skills and educational credentials are too marginal to enable them to find as good a job, if any, in the "outside world."

Training—Because of the Center's need for skilled workers, and the workers' need to make their skills transferable and to acquire upward mobility, training is highly important at NENA. At NENA, this has happened in a rather informal and unplanned manner. Early emphasis went into specific job and task preparation; little went into creating truly transferable credentials. Thus, to prepare the Center for opening day, "instant" clerks, receptionists, stock room attendants, maintenance men, medical assistants and so on were rapidly created. Later substantial effort went into teaching English and Spanish and preparing students to pass the high school equivalency exam. A number now attend community or regular college part time; others are apprenticed in the pharmacy and the laboratory, and one, now a medical emergency technician, has been accepted into medical school for 1974.

The result of all this activity is that the NENA Health Center, set up in opposition to the teaching hospitals, has in some ways become a teaching institution. But it does not prepare an elite at the expense of the community. Rather, it has resulted in the Center's first housekeeper becoming supervisor of dental assistants, a former center clerk becoming its office manager, and a woman medical assistant preparing to graduate from a training course to enter the hitherto all male field of medical emergency technicians who ride the ambulance. All this has been done with virtually no budget, training staff or separate training program.

Workers' Organization—The very insecurity which has sent so many workers into training programs for self-advancement of NENA has not yet led to major steps towards a workers' organization or union. In the beginning, a common sense of loyalty to the Center and to the Lower East Side united all levels of the staff. Later a staff association was formed,

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**NENA Through Different Eyes**

"NENA is like a clinic, and not like a clinic. If I come here, and my daughter needs me, everyone knows where to find me."

—A NENA patient

"Development of the Health Center was the paramount concern of the Health Committee. They just didn't have time to wage the wider struggles."

—Past Chairman
NENA Community Board

"The New York Infirmary is O.K. It's kind of blue-blooded about so many of our Black and Puerto Rican patients being in semi-private status."

—A NENA physician

"Morale is usually low among workers. It affects the patients. Like on check day, when people were complaining no pay raise had come through—and there was a dead O.D. stretched out in the back room."

—A NENA Nurse

"You can't get things done without conflict. Whether it's the health system, education, housing — the people must struggle for power."

—A Community Activist

"The New York Infirmary does not control us, though they do make life difficult at times."

—A NENA Physician
exclusive of professionals and administrators, to speak for employee concerns at administration meetings and also to secure passage and then observance of a code of personnel practices. But the association has not captured the allegiance of large numbers of staff members. Nonetheless, the group does have a seat on the Health Committee and is able to voice the concerns of staff members, though it does not enjoy the right to vote or opportunity to appear at closed executive sessions.

More energy within the staff goes, in fact, into an elected grievance committee, which arbitrates individual complaints. Issues arise on a personal basis rather than collectively as might happen through the staff association.

There is no union at NENA. Anti-union thinking for many on the Lower East Side began in 1968 and 1969 following the teachers’ union strikes. These strikes appeared to many poor parents to be against their children, their community and their schools, on the part of mostly white teachers led by an ambitious and racist union leadership.

At the same time, many staff workers felt suspicious of the only potential NENA union, Local 1199 of the Drug and Hospital Workers’ Union. The union opposed various community control struggles at Gouverneur Clinic and Beth Israel Hospital, both in the NENA neighborhood, in 1968, 1969 and 1970 (See BULLETIN, July-August 1969, February 1970). As a result, many on the staff view unionism as being opposed to community interests. And since NENA is above all a community institution, under a fair measure of community control, union sentiment has not developed.

The professional, technical and administrative staff at NENA are a varied group, ethnically, politically, and in terms of dedication to the Center. Interviews for attitude acceptability with the Health Committee have made little difference. One reason, of course, is that the extreme shortage of interested, available and qualified professionals, particularly physicians, makes such activity more ritual than meaningful. In any event, the professional staff do not act as a unified influence at the Health Center.

**NENA’s Accomplishments**

NENA’s accomplishments are many:
- Increase in Services—NENA receives many thousands of visits per year. It reaches more people in its district than any other health service, yet it has never recruited patients. Almost one hundred percent of the children in the surrounding tenement blocks are registered at the Center.
- A Neighborhood Atmosphere—NENA is truly a neighborhood center. Spanish is heard in the hallways, children are always present, many of the workers are patients’ neighbors. Little wonder a Puerto Rican mother can say: “NENA is like a clinic, but not like a clinic. If I come here, and my daughter needs me, everyone knows where to find me.” NENA belongs to the people.
- A Proud Center Staff—Most workers are intensely proud of NENA. They speak of serving their community. A medical assistant will search throughout the building to find an answer to a patient’s question. A medical emergency technician boasts of the efficiency of his ambulance shift. Many staff members make it a point “to take care of business”—that means breaking through red tape to get something done for a patient. Even former staff respect NENA: “People who have left work at NENA never talk about it as ‘they.’ They still say ‘we.’ We still feel part of it.”
- Community Initiated and Community Controlled—NENA was started by community people, and even though its Health Committee is not perfect, it is still controlled by people who live in the community served by the Center. Most of the board and staff obtain their health care from the Center. NENA is one of the very few examples of a health service sponsored and controlled by a non-establishment community body in a big city slum.
- An Independent Health Service—NENA is independent of the major medical centers that dominate the Lower East Side. Through its relationship to the New York hospital system—National Health System and the major teaching hospitals—NENA can achieve a degree of independence which enables it to differ from other community centers.

"There was a mixed message in the way some of us from the white new left looked at structure—and the very literal way others in the administration looked at it. So for safety, people retreated into rigidly defined jobs."

—Judy Graham
Former Social Service Director

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York Infirmary for inpatient care, NENA has broken away from complete dependence for back-up services on a medical school or large teaching center. NENA is also independent of these major centers by virtue of its funding, which comes directly from the federal government to its own community organization. Two-thirds of NENA's $2 million budget comes from the US Public Health Service, the rest from Medicaid.

**Contradictions**

But NENA is a bundle of contradictions. For each accomplishment the Center faces a bind:

- **Quantity vs. Quality**—Though NENA has vastly increased the quantity of health services on the Lower East Side, its major quality service—the comprehensive, family care program run by health teams—has had virtually closed enrollment for over two years.

- **Neighborhood vs. OPD Atmosphere**—Like its neighborhood, NENA is overcrowded and teeming with people. One mother describes the screening area: "I never know what's going on there. People have little time for you. People are rough and don't care. You spend hours waiting when you are sick. The staff are rapping when people sit and wait. There is no explanation why you are waiting. It is just horrible, like a hospital emergency room. Patients are just numbers: Go here! Go there! I don't know what people would do in a real emergency. I once saw a person with a real emergency refused care by a receptionist because he wasn't registered."

- **Staff Pride vs. Low Staff Morale**—Though most of NENA's staff is proud to work there, staff morale has been sagging. As the Center becomes more bureaucratized, the workers feel a corresponding increase in alienation. "You can't run this place like a business. It is all going on computers. People have a number instead of a name. So does the job. Time cards are like a god. It resembles the Board of Education. The next thing a patient will come in, they'll hook him onto a computer and they'll find out what's wrong with him." Another worker declared: "There are no overall staff meetings to explain what's going on. People are very discouraged."

- **Health Committee Control vs. Patient Accountability**—At NENA there certainly is a significant degree of control by people who live near and use the Center. But there are no mechanisms, beyond a suggestion box, for patients to play a role in formulating the policies of the Center. No meetings of patients are held. No patient advocate system exists. And the Health Committee has been reluctant to establish a community outreach program that might combine health education and political education.

- **Independence vs. Federal Controls**—With all the mechanisms that NENA has devised to keep it independent of the medical establishment, it is still captive to the federal government. Each year the whole Center comes up for review, including its pattern of services, table of organization, salary levels, future plans and so on. Renewal of the grant is contingent on Public Health Service approval of all these matters, as well as its own availability of funds. NENA's demonstration grant expires next year. While the Public Health Service will hopefully grant some kind of extension, there is no guarantee how long federal subsidy will continue. With repeated cuts in Medicaid, the prospect of making the Center self-supporting is dismal. Ultimately, NENA has no independence.

"Community control, comprehensive care, good peer relations—they're all inherently impossible goals because we're all stuck in the US health system."

—Former Employee

Everyone agrees that the NENA Health Center faces manifold and serious problems. More serious, however, is the fact that even a tentative approach to a solution is unclear.

No agent for potential change is evident with the Health Committee or the NENA staff. Most of the nonprofessional workers who have attempted to bring changes to NENA have left the staff or are now absorbed in school. The remaining nonprofessionals are discouraged by staff divisions. They point out that "everyone seems to be out for himself."

Among professionals similar discour-
agement exists. One Black nurse said: "NENA has helped me to be less idealistic, more pragmatic and unfortunately more apathetic." This nurse was upset with the lack of staff response to a far smaller then expected wage increase. "I can see now how people can be done in," she said.

White professionals have always been in an ambivalent position at NENA. They were recruited because of their professional or administrative skills. But because they felt that political initiative should lie in the hands of community residents, most of whom are Puerto Rican or Black nonprofessionals, they have been unable to break out of their constricted professional roles.

The NENA administration, rather than being a force for change, today appears to be isolated from the basic concerns of the staff and even of the patients. Some do not recognize, or else cannot bring themselves to believe, how discouraged many of NENA's best workers are at all levels, regardless of political persuasion.

The few self-conscious radicals on the staff—professionals and nonprofessionals—have been relatively ineffective. Commented one physician: "Lately the radicals have confronted the administration on specific grievances. They have done almost no educational work to explain their views to the staff as a whole. The effect has been by and large antagonistic. There is sympathy with some of their aims, but a fear of losing one's job if one joins them. There is also skepticism because so few of the radicals truly take care of their work. One is lackadaisical about his work; another is always late, and so on."

Some might view patients themselves as a possible political force. But so far there is no evidence of patient organization.

Why is there no evident change agent at NENA? The major reason seems to be a deeply ingrained sense of NENA's marginality. As one Puerto Rican worker summarized it: "People are all into their own thing. They are off at school, or they are lining up second jobs, because they're afraid the Center's deficit is so huge it will have to close at the end of the summer." This feeling of NENA's marginality and lack of permanence extends into the community. People recognize that the locus of power in health on the Lower East Side still resides at NYU-Bellevue and Beth Israel.

These problems all stem from NENA's profound external limitations. Without a massive infusion of resources, it cannot possibly offer quality services to all who need them. Yet, in the competition for federal funds, NENA ($1.4 million a year in federal grants) with all its independence is still far outstripped by NYU and Beth Israel Medical Centers, which garner more than $50 million each year in government grants. So NENA remains a minor irritant to the medical empire. Unless the community, the Health Committee, and the workers see these forces as "the enemy" and focus their energy there, the prognosis for change at NENA is guarded.

—Des Callan and Oliver Fein

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