The Failure of Comprehensive Health Services to Serve the Urban Chicano

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During hearings before the President's Committee on Health Education held in San Francisco on January 19, 1972, I testified that, as far as the Chicanos of Santa Clara County whom I represented were concerned, health programs designed to improve the quality of life, such as so-called comprehensive health programs, are both irrational and border on irresponsibility. They are neither comprehensive, nor do they appropriately address issues of health as viewed by Chicanos, and they cannot accurately be called programs. I further mentioned three underlying reasons why these programs do not help Chicanos.

1. An Anglo middle-class syndrome with little empathy for and considerable confusion about Chicanos permeates their staffs.
2. The methods of providing health services are often ineffective because the rationale for choosing them is at variance with the structures of Chicano social and community organizations.
3. The meaning of comprehensive health has not been defined with a Chicano perspective.

The purpose of this essay is to expand further on these reasons which, I believe, greatly contribute to the denial of a decent quality of life by ineffective delivery of health services to Chicanos. I shall focus somewhat on mental health, but I believe my observations are applicable to comprehensive health services in general. The term "comprehensive health services," as I use it, refers to a broad spectrum of programs necessary to maintain a desirable quality of life such as, but not limited to, medical, dental, and mental

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ETHNIC ETYMOLOGY

A variety of terms are used to describe the Chicano, including Indio, Latino, Hispano, and Mexican American. The three major terms are:

Mexican-American — Use of the hyphenated term is directly linked to the Mexican-American War of 1848. For Mexican intellectuals, the term denotes conquest.

Mexican American — The nonhyphenated term emerged in the early 1950s as a result of political activities of returning World War II soldiers. The term denotes struggle for equal status.

Chicano — This self-identity term grew out of the Chicano civil rights movement. It has no reference to acquiring equal status with Anglo society.

health, preventive and environmental health, and nursing and health education services. My overt and avowed intent is to promote serious concern and action in redesigning health service delivery systems to improve the quality of life of Chicanos.

Whether by accident or design, policies and attitudes governing health programs represent an ethnocentric viewpoint from the Chicano perspective. Many health planners and administrators have either ignored Chicano needs or premised services on stereotypes of this minority group.

Chicano Stereotypes

In my experience, health officials often view Chicanos as "Mexican-Americans," a defranchised minority group marginally, but temporarily, existing within a highly competitive Anglo society and ultimately destined for acculturation. Furthermore, there is an assumption that the Spanish language, the Catholic religion, and a homogeneous culture permeate the Mexican-American universe.

At one end of a popularly accepted sociocultural spectrum of the Chicano is the newly arrived Mexican immigrant, often characterized as ignorant, unacculturated, and superstitious. Over a period of time, the immigrant is said to adopt some norms of Anglo society but overtly retains his Mexican folk culture orientation. In the middle of the spectrum is the Mexican American living in both Mexican and Anglo worlds. Mexican Americans consciously attempting culture transfer to Anglo society are frequently viewed as experiencing anxiety about self-identity and "cognitive dissonance" because of competing Anglo and Chicano values to the extent that complete role identity with either group is virtually impossible.

At the far end of the spectrum are Mexican Americans fitting the Anglo middle class model. Many of these Mexican Americans are viewed

as having abandoned their Mexicanism because upward social mobility has caused or required separation from their ethnic group.

One can only deduce from these stereotypes that the Mexican Americans are their own worst enemies. The principal difficulty of using the social spectrum model to describe Mexican Americans is that it does not represent reality. These prototypes are akin to the caricatures of the Ozark Mountain man or so-called city slicker as accurately depicting Anglo society. Is Anglo society Irish, German, Italian, Polish, Jewish, or English? Obviously, there is considerable diversity in Chicano society—Indio, Latino, Spanish, Hispano, Mexican, and Mexican American—and this health professionals must understand.

A legitimate way of considering Mexican Americans is as a complex, heterogeneous group affected by numerous and equally complex internal and external forces. Mexican Americans have been affected in varying degrees by Spanish, Indian, and Mexican culture, but considerably more so by contemporary Chicano and Anglo value influences. Mexican Americans face powerful forces imposed by the dominant society such as discrimination, prejudice, and exclusion from participation in policy and program decisions. Thus, what is often measured in various health studies is behavior or attitudes that are reactions to these external conditions imposed by the dominant society.

Chicano Realities

It is important, therefore, that health planners and administrators understand the following salient points regarding urban Chicanos:

1. Of some 6 million Chicanos, 90 percent reside in urban areas. (This in itself, however, does not constitute urbanization in terms of having access to or being involved in urban institutions.)
2. Chicanos are a highly diverse, heterogeneous ethnic group which faces a wide range of socioeconomic problems.
3. Many Chicanos resentfully view themselves as refugees in their own country.

Health planners and administrators would be wise to consider seriously these points in formulating programs and in performring their duties. For example, programs should incorporate a flexible delivery system directed at the heterogeneous urban Chicano. This flexibility can be accomplished through employing bilingual, bicultural community health workers, distribution of bilingual health literature, and health information spot announcements to Chicano radio stations, using mobile clinics where appropriate, and making staff available during evening hours. Health programs should be operated in church buildings, central shopping areas, and other strategic points in the Chicano communities with the cooperation and involvement of indigenous organizations. Health professionals also need to address themselves to the diverse issues affecting the quality of life of Chicanos, such as housing, income maintenance, and municipal and social services. Cooperative relations and case follow-through mechanisms cutting across various agencies should be established. Most important, programs designed to "help" Chicanos become more like Anglos must be avoided. Rather, health programs to be effective must recognize Chicanos as individual persons with distinctive sociocultural attributes and health needs.

Limitations of the Literature

As with the stereotypes, health-relevant literature about Chicanos leaves much to be desired. At the risk of simplification I maintain, as do a small minority of health educators and persons familiar with Chicano needs, that most contemporary research on Chicanos is inaccurate and perpetuates the previously noted stereotypes. Most studies describe in general terms various values, attitudes, and behavior of Chicanos and those socioeconomic conditions that perpetuate problems. Such literature, however, cannot be generalized as accurately describing or promoting understanding of Chicano health needs or practices per se.

Moustafa and Weiss noted "glaring deficiencies of information" on Mexican American mortality rates, morbidity characteristics, mental illness, and health attitudes and practices (*1*). With rare exceptions, the comparatively limited sociological and anthropological literature touching upon health issues does little justice to the Chicano. Consequently, conclusions and data based on limited research are often used as empirical evidence upon which to base human service agency policies and programs.

Folk Culture Syndrome

Romano has eloquently argued that some of the most widely accepted contemporary studies on Chicanos simply reinforce stereotypes of distorted traditional folk culture traits (*2*). Social scientists in particular, such as Rubel (*3*), Heller

(*4*), Madsen (*5*), Saunders (*6*), and others have fallen victim to the folk culture syndrome at the expense of a realistic understanding of the pluralistic nature of the Chicano. Their studies are generally regarded by those intimately knowledgeable about Chicanos as superficial. They do not explain the underlying dynamics, and they inadequately interpret cultural expressions of health practices and beliefs.

Morales has charged that mental health research is also misdirected, fails to distinguish Chicano attributes accurately, and generally perpetuates ethnocentric interpretations (*7*):

> Years ago the answer was that the Mexicans were inferior; later socially inferior, in subsequent years . . . the emphasis was placed on a Mexican American cultural value system that did not seem to possess the [Anglo] value of "rugged individualism" and "aggressive motivation . . ."

Morales further argues, and I believe correctly so, that popular metaphors used to explain Chicano beliefs and behavior, such as the "culture of poverty," ignore the structural conditions imposed by the dominant society or external circumstances as conditioning the life patterns of the poor. Such metaphors merely serve to perpetuate "dominant group perspectives of [the] intellectual strategist."

Cabrera (*8*) also rejects the validity of studies which assume a folk culture orientation on the basis that the influence of Mexican culture characteristics is dependent on the framework set for them by the dominant culture. Moore (*9*) has criticized folk culture studies because the number of Chicanos possessing such characteristics is rapidly declining; moreover, when one views Chicanos as a variant subculture within the United States, the folk culture orientation is severely weakened. Casavantes (*10*) has stressed the need to distinguish clearly between Chicano cultural attributes, as expressed by beliefs and practices, and those exhibited by people living in poverty, beliefs and practices that are attributed carte blanche to Chicanos as inherent characteristics.

Health officials should be wary of studies which embrace unquestioningly the folk culture model and draw generalized conclusions on Chicano rates, treatment, and perceptions of various illnesses. Examples of such studies are those of Ellis (*11*), Madsen (*12*), Karno (*13*), Karno and Edgerton (*14*), and Jaco (*15*).

Health planners and administrators should reassess carefully their perceptions of Chicanos and exercise considerable caution in unquestioningly accepting studies on Chicanos by self-acclaimed experts. Also, I would strongly urge health officials to learn more about the Chicano communities that some proclaimed to, but have failed to serve adequately. They can gain some insights by becoming part of a Chicano community, by walking through neighborhoods, talking to residents, attending group meetings, and the like.

Community, Barrio, and Colonia

Heretofore, Chicano communities have generally been regarded solely as barrios or colonias within specific spatial boundaries, invariably located "across the tracks" and rampant with social problems. The concept of the Chicano community begs a new definition.

For purposes of clarification, a barrio is commonly defined as a neighborhood or vecindad with specific geographic boundaries whose resident population is predominantly Chicano. A colonia is composed of several barrios and refers to Chicanos within a community in general. Barrio is an exclusive term whereas colonia is an inclusive term.

One research report delineated four Chicano community types as the plaza or central city, suburban, rural, and labor camp (*9*). It is interesting that these typologies closely parallel those described by Borgardus in 1926 (*16*). The utility of these traditional concepts as constituting Chicano community types is perhaps subject to modification, particularly when one considers that a substantial percentage of Chicanos now reside in urban areas.

Chicano communities are generally regarded as a variant microcosm of the dominant society, interrelating with its external institutional structures, such as the police, schools, and so forth. From this premise many decisions are made on how to serve Chicano communities by a variety of human services agencies. The disadvantage of this concept is that Chicanos are viewed as acting out roles at a level which confronts their immediate environment and circumstances without regard to the legitimacy or origins of the interactions in relation to the Chicanos' own ethnic frame. Chicanos are viewed as differential people within a common social system of the dominant society, of which they may or may not be a part. All too often I have observed various health service agencies seeking out the Chicano "community" and "consumer" participation solely for the purpose

of legitimizing their programs with little regard for the integration of their services into the existing structure of the Chicano communities.

I would suggest to health planners and administrators that there is no single Chicano community, but rather divergent and heterogeneous communities definable primarily by internal social interaction and interdependence and less so by physical or Anglo institutional considerations. I further propose that the notion of Chicano communities is a multivariate concept denoting a collective ethnic sharing common elements of a heterogeneous culture in a dynamically structured society.

The issue is that Chicanos and the concept of community should be viewed interdependently rather than separately. Failure to make the distinction has led to "ticky-tacky" programs of health services superimposed on inaccurate concepts of Chicano community structures.

Reconciling Chicano and Modern Medicine

Clark's exceptional study (*17*) of health in a Chicano barrio noted the reciprocal need to improve communication in order to reduce barriers in securing health services. Chicanos would accept Anglo medicine if its efficacy were demonstrated. Clark noted the important need to reconcile modern medical practices with Chicano medical practices (for example, the use of herbal medicines) and for Anglo medical personnel to study Chicano culture and to find more effective means of providing the financial assistance Chicanos need to obtain quality medical services.

Kiev (*18*) noted that Chicanos would not accept modern psychiatry because it is depersonalized and does not recognize folk ailments. Kiev maintains that curanderas (folk health practitioners) enjoy success, and indeed are successful, because they relate to, rather than isolate the patient's institutional environment and belief system.

Torrey (*19*) has observed that what are called "new" or "bold" community health services are nothing less than a "cautious tinkering with the status quo." Torrey correctly advocates that mental health services are irrelevant to the Chicano community because they are inaccessible, class-bound, culture-bound, caste-bound, because there are language difficulties, and because Chicanos have their own system of mental health services. These are often provided by mental health ombudsmen such as curanderas, priests, midwives, and herbalists. In a similar vein, Philippus (*20*) argues that the delivery of mental health services to Chicanos would be more effective by substituting, for the traditional bureacratic system, a more informed, personal approach with emphasis on using neighborhood persons.

Martinez and Martin (*21*) concluded that there is a prevailing and widespread belief in folk illnesses and use of folk healers among urban Chicanos, but that "relief for folk illnesses is rarely sought from physicians" because of their lack of knowledge, faith, or understanding. They appropriately point out, however, that there is a dual system of treating illness (*21*):

> Participation in the system of folk beliefs and curative practices by no means, however, precludes reliance upon physicians and use of medical services for health problems not defined by folk concepts. Thus many Mexican Americans participate in two insular systems of health beliefs and health care.

The Chicano health care system is composed of various methods and resources:

1. The Catholic Church, which is used mainly by middle-aged or older women in helping to work out grief and, on occasion, mental health problems using the church velorio or rosary
2. The fundamentalist Protestant church, in which family life is very involved with an emphasis on acceptance of "God's will"
3. The pharmacy, from which Chicanos will usually try to obtain various patent drugs to treat illnesses before going to a physician
4. Drugs and herbs from Mexico, which are usually purchased over the counter (penicillin, for example) and shared with family members and friends
5. Go to Mexico to treat serious illness, such as cancer, to have babies, or simply "to die"
6. Seeking advice from one's madrina (godmother) or friendly older "wise women"
7. Curandera, a folk practitioner who uses various folk cures such as herbs to treat illness
8. Bruja, a witch who uses spells to counter or overcome imposed or projected illness
9. Chiropractors, who often have a large Chicano following because their practice is based on personalizmo and costs less than physicians, and some chiropracters speak Spanish.

My own observations have been that health professionals are incredibly ignorant about, or unable to reconcile, the functional aspects of an alternate health care system, such as folk treatment by curanderas, with modern medical practices. Physicians, particularly, are indifferent or

critical of folk treatment, about which they know little, to the point of ridiculing it.

On numerous occasions I have observed the successful treatment of various illnesses by curanderas in the face of contrary medical opinions. Curanderas play a significant role because their health treatment is based on empirical observation and cognitive pragmatism.

The most prominent folk illnesses various researchers discuss are mal ojo (evil eye), susto (spirit loss, fright), mal puesto (hex), empacho (surfeit), and caída de mollera (fallen fontanelle). In addition to these maladies, there are illnesses said to be caused by brujas such as envidia (envy) and sexual impotence. A wide range of explanations and theories as to the causes, symptoms, and treatment of these illnesses are found in other accounts. What is important to note is that folk illnesses are generally pragmatically and effectively treated.

On a personal note, I believe that my severely burned hand was saved by a curandera's treatment, although physicians argued for amputation because of severe infection. I also recall how, as a child, I was taught mouth-to-mouth resuscitation by a curandera only to learn some 12 years later of this new medical discovery. I raise these examples simply to underscore the existence of various and valid health practices exclusive of modern medicine.

Why Chicanos Are Not Reached

It should be clear that comprehensive health services are urgently needed in the Chicano communities and are, in fact, sought. But Chicanos' lack of money for health services and the unconscious cultural conflicts they often experience in receiving treatment render community folk health practices legitimate and a realistic process of providing health care.

Although essential medical and health care is generally available, it is not readily accessible to many urban Chicanos. A number of studies of health needs have documented barriers to care such as transportation, language difficulties, cost, and sociocultural differences. But many Chicanos who do reach medical care, often as a last resort, also encounter service barriers in the form of inconsiderate treatment. Skillicorn, in documenting a feasibility study for a health program in a Chicano barrio, noted (*22a*):

> Infrequently is the possibility taken into consideration . . . that regardless of the excellence of scientific medical treatment, the methods by which it is dispensed may be unappealing, unsuitable or even unacceptable.

Chicanos tell of numerous examples of "Me hacen mala cara" (they made an ugly face at me). Treatment ranged from overcharging to outright maltreatment.

Mr. P., for example, was charged $30 for treatment of headaches by being told to take two aspirins. (Eyeglasses corrected the problem later.)

Mrs. B. was told that unless she immediately paid an $18 office fee (rather than being billed) she would be put in jail.

Mr. R. arrived at the appointed time at a clinic for a medical examination for a heart condition and waited 4 hours, only to be told to return the following day, when he waited for 3 hours. On finally seeing the physician, no service was rendered because of no interpreter. The physician refused to call in a Spanish-speaking receptionist because "Mexicans should learn English."

Isolated examples? Hardly. Chicanos, like other urban poor, are victims of professional and class prejudices of the health profession.

To be effective, health programs must reflect a Chicano community orientation, be a personalized system of service, and capitalize on the existing treatment system. Sanchez correctly stated that the very notion of providing symptom-oriented health services must be redefined and health programs redesigned within the framework of th Chicano community (*23*):

> The health of an individual and community does not exist in a vacuum; rather, it is related not only to the total environment but also to other individuals and the network of interrelationships that give life to the total community . . . Hence the well being of an individual and community must be studied from within the *barrio* with its complex network of relationships. It must be kept in mind that the barrio is a social institution which affects the lives of those who live in it.

To my knowledge there are no comprehensive health programs that reflect an understanding of, or are integrated to, Chicano community life styles. Rather I have found health programs to reflect an Anglo middle-class mentality—programs are defined within a framework of the medical and psychoanalytic models and are premised on the sociological assumption of assimilation and a political philosophy of colonialism. Health officials implicitly suggest that Chicanos are at fault for their medical and mental illnesses and for not using "available" health services agencies.

It makes no sense for health agencies continually to attempt to deal with the effects of health problems without also focusing on the causes. The agencies, I advocate, are part of the

cause of poor health services to Chicanos and, if they hope to be more effective, they must change.

Comprehensive health service programs from the Federal to the local level have seriously failed in their responsibility to the Chicano people of this nation. Nowhere is this failure more evident than in the lack of training and the underrepresentation of Chicanos in management levels of health programs.

Padilla has suggested that the failure to meet Chicano mental health needs, for example, can be traced to psychologists in general and the American Psychological Association (APA) in particular. In his lucid article on the relationship between psychology and Chicanos, Padilla (*24*) cites a survey by Boxley and Wagner. "Of 78.6% of all Universities with APA and non-APA approved clinical training programs in the United States reporting, there were only six Chicano graduate students enrolled."

A similar charge can be leveled against the American Medical Association, dental and nursing associations, and training institutions of the health professions for failing to attract Chicanos into these professions.

Suggestions for Reform

In advocating more open and realistic entrance policies for training institutions and opportunities for equal employment in health programs, I often encounter considerable sensitivity. Reactions range from cries of "lowering professional standards" and "reverse discrimination" to strong or subtle resistance. There is little merit or substance to such emotional rhetoric, but it does reveal existing sentiments of racism tantamount to acknowledging de facto discrimination. The occasional admittance of a Chicano into a health profession or an occasional award of a $1,500 scholarship is hardly cause for jubilation.

Robert Olivas testified before the Civil Rights Oversight Subcommittee ("Underrepresentation of Spanish Speaking Employees at the Health Services and Mental Health Administration") in Washington, D.C., on March 10, 1972. He stated, "physical health and mental health services can best be administered and delivered to a Spanish speaking population by Spanish speaking administrators and practitioners."

Despite documented needs for Chicano health administrators and practitioners, they are woefully scarce.

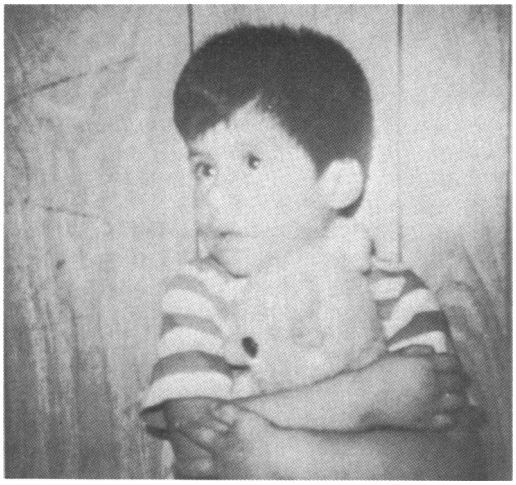
How then, in the light of these observations, might comprehensive health programs be improved to reach Chicano communities? I offer the following recommendations, which I have previously advocated, to improve the quality of life and the relevancy of health programs:

- Serious actions be taken to recruit and train Chicano health and mental health professionals;
- Health curriculums at graduate professional schools be modified to reflect existing realities, and new courses regarding community health be introduced;
- Health programs be redesigned to recognize and incorporate the diverse cultural, linguistic, and ethnic elements appropriate to the clients;
- Chicanos be recruited as paid consultants to serve on policy and grant approval boards;
- Health officials actively support innovative manpower training programs such as those for community health and mental health workers;
- Health professionals educate themselves as to Chicano health needs, community dynamics, and in particular, the existing methods of health treatment, and,
- A comprehensive Chicano health needs study be commissioned, to be conducted by Chicanos.

It is indeed tempting to list a series of actions necessary to implement these suggestions. But in the final analysis, the adoption of these or any other suggestions is to a large degree dependent on the social orientation and perspective of health administrators, many of whom, I believe, welcome viable suggestions in eradicating health care inequities. The pragmatic realities are, however, that little has changed in the dismal quality of life of many urban Chicanos despite repeated evidence and appeals to change the status quo.

The existence of forces which perpetuate limited opportunities for growth and decision-making involvement has led to the manifestation of the Chicano movement as evidenced by the social criticism of "El Grito," the cries of "huelga," increasing Chicano student activity, and community demands on "the system." Chicanos advocate, justifiably so, either a policy of self-determination and community control of institutions which have failed to serve them or the establishment of parallel institutions when necessary and appropriate, or both steps. Community health programs are no exception to this effort.

The times and circumstances are changing. Unless positive actions are taken soon to correct health service inequities and improve the quality of life, community controversy over the admin-



CHICANO CHILDREN ARE OFTEN ISOLATED IN THE BARRIO

istration and funding of health and medical programs will increase. I believe that conflict and controversy are neither desirable nor necessary, since existing health programs can be restructured internally to meet Chicano and other minority health needs. Rather than health administrators applying for Federal grants to give more of the same efficiently inefficient services in Chicano barrios, changes such as I have suggested could come about without Federal assistance—this in itself is change.

Moreover, it is imperative that health administrators clearly understand that the "service station" mentality of providing health services is inappropriate and ineffective in Chicano communities. Chicanos should not be expected to "plug into" a health care system that violates their culture and fails to recognize or effectively meet their needs.

Several fundamental changes, above all, must be made to improve the quality of life of urban Chicanos in regard to health services. First, program services must be accessible, and I have offered some suggestions on how this could be accomplished. Accessibility, however, implies radically changing the process of rendering services, and this transformation means a philosophical change from a strictly service orientation to a highly diversified multidisciplinary delivery process—the health system, in other words, must become open. This change will occur only when the misplaced sense of health "professionalism" itself changes.

Second, the functions of the health professional must be modified to deal with the ever-increasing and complex community issues impinging on the quality of life, of which health is but one critical element. I purposely place the burden on the health professionals to change the way they function and to change the present health service system because they are in the system. Internal advocacy for change, including increasing the number of Chicano health professionals in key positions and changing health curriculums, is much more effective than demands made from outside the health professions.

Third, I believe that the quality of life and Chicano health issues must be put into national perspective. A national conference for the purpose of documenting Chicano health needs, developing research projects, proposing alternative health systems, and formulating a national health policy which reflects a Chicano perspective would be invaluable in setting a new tone in health programs.

What can Chicanos do to improve their quality of life, including their health situation? A great deal is said about individual responsibility for health care. While I agree with the intent of individual responsibility, I disagree with its implicit assumption, since such a position assumes that individual resources and accessibility to health care exist. To assume that poor urban Chicanos can exercise individual health care responsibility within the context of the existing health system is naive. Let me be clear that Chicanos do exercise individual health care, but it is primarily evident in their use of the alternative health care system.

Chicanos desire the same quality and accessibility of health care enjoyed by others (preference for private physicians over institutional care, for example), and they are particularly tenacious about obtaining medical treatment when necessary. But costs, inaccessibility, social circumstances, and prejudice and inconsiderate treatment by health professionals virtually force many Chicanos to use their own immediate resources for health or medical treatment, and they resort to the present health system only in dire emergencies.

When asked by Chicanos what they can do to change existing health systems, I usually refer them to Saul Alinsky's community organization tactics. I have limited faith in Chicano needs being met by holding a series of meetings with health officials to "discuss the issues." Since there are usually more than sufficient grounds for legal action against health programs, Chicanos should first file suits and then attempt to resolve issues,

since they can then do so from a position of some power. I raise the example simply to illustrate that external efforts for change often have to be dramatic, forceful, and occur at a high enough level to have a lasting effect.

Conclusion

The present health system is a closed system which, to Chicanos, is a mockery of "quality health," "freedom of choice," "fee for services," and professional principles. Refusal to implement necessary action to meet minority health needs perpetuates the problem, invites controversy, and increases the creditability gap health professionals (and most other human service professionals) suffer in Chicano communities.

I quite agree with Skillicorn that "C-care" must be developed in Chicano barrios (*22b*) :

Congenial—personal, courteous, respectful care;
Convenient—accessible and minimal waiting;
Complete—not incomplete, assembly line care;
Consistent—familiar, predictable, continuous care; and,
Compassionate—concerned, caring care.

The reality of many Chicano communities is the lack of a decent quality of life and immense suffering for many, which is both senseless and needless if health care were only appropriately and effectively delivered in the barrio. Chicanos are doing the best they can for themselves under existing circumstances. Health professionals now need to examine critically their own social consciences.

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