A Community Health Project in Ten-Year Perspective

DAVID SAVITZ, MD, MPH, and EVEYLN A. MAUSS, PhD

THE 1960S BROUGHT A STRONG IMPULSE toward social reform in the United States. Attention centered particularly on the deprivations experienced by various racial and ethnic minorities and people living in poverty. Almost all aspects of the lives of the members of such groups became subject to scrutiny and ameliorist activity. As a consequence, the health status of the disadvantaged and the health care services available to them received considerable attention (*1–4*).

At least two major reformist viewpoints were expressed. Many persons, particularly within the health professions, pointed out the poor health indices of disadvantaged groups as compared with the rest of the population and criticized the quality of the health services available to minorities and the poor. These critics believed that improvement in health services was desirable both as a matter of social justice and as a means for bettering the health status of these groups (*5*).

Others holding reformist views were more concerned with broader political action and community development on behalf of disadvantaged groups. They considered ill health in part to be a cause as well as an effect of the disadvantaged status and as something that needed to be corrected as a prelude to improvement of the overall life situation of such groups. Furthermore, they believed that health care projects, being usually relatively noncontroversial, might stimulate the constructive politicization of disadvantaged communities. Such projects, they thought, might facilitate community organization, and that in turn could generate change in more fundamental areas of economic and political status (*6*). Donabedian has characterized these two viewpoints as belonging to the health planner, on the one hand, and to the social reformer, on the other (*7*).

Thus, a number of projects were launched in the sixties in an attempt to improve existing health service arrangements or create new ones, such as neighborhood health centers (*8, 9*). In many cases, such projects were sponsored by existing health care institutions, for example, hospitals (*10, 11*), medical schools (*12*), and health departments (*13*). Institution-related projects were usually supported through Federal agencies, such as the Office of Economic Opportunity, the Model Cities Program, and various offices of the Department of Health, Education, and Welfare. As time went on, more and more consumer or community-based organizations received funding to establish health projects (*14, 15*). With little or no funding, however, many smaller projects were launched by students and other volunteers anxious to participate in the reformist activities of the time (*16–18*).

The health projects had detractors as well as supporters, even aside from those who simply favored maintenance of the status quo. Critics pointed out that the formidable expenditure of energy and other

☐ *Dr. Savitz is currently engaged in the private practice of internal medicine in Boston, Mass., and Dr. Mauss is director of the Combined Degree Program in Dental Education at New York University and a member of the Department of Physiology-Pharmacology of that university's College of Dentistry. At the time of the project, Dr. Savitz was a research associate in biochemistry at the National Institutes of Health, Bethesda, Md., and Dr. Mauss was engaged in teaching and research in the Department of Physiology-Pharmacology of the College of Dentistry, New York University.*

Tearsheet requests to David Savitz, MD, 268 Grove St., Auburndale, Mass. 02166.

resources on temporary projects effectively precluded application of these resources to the solution of basic problems; that the special technological nature of health care made health projects poor models for community action generally; that health care was usually of relatively low priority for disadvantaged groups (compared, for instance, with jobs, income, housing, and so forth); and that in any case, health status was determined by several factors besides direct health services. Even now in the late 1970s, no clear consensus has been reached on these issues.

In the summer of 1965, when whites were still participating fully in the civil rights movement, the United Presbyterian Church USA undertook support of a health project for the black population of Amelia County, Va. Professional responsibility for the project was assumed by the Metropolitan Washington (D.C.) chapter of the Medical Committee for Human Rights. Amelia was selected for this and several other civil rights and community organization efforts that summer because of the initiative of the local black minister. The county was adjacent and demographically similar to Prince Edward County (which had gone so far as to close its public schools rather than maintain them on a court-ordered integrated basis). The Amelia health program was an example of a volunteer-staffed project for a disadvantaged group which was related to broader community action objectives.

In the light of the foregoing considerations, we believed it would be useful to review the Amelia experience a decade later. One of us (D.S.), a physician, had been fully engaged in the Amelia health project from its inception, through its implementation, on to its conclusion and evaluation. The other author (E.A.M.), a physiologist interested in health care delivery, spent 2 weeks in Amelia in 1965 assisting with various aspects of the health project. She was accompanied at that time by a friend who was actively involved in the civil rights movement. Of the three, D.S. was the first to revisit Amelia (in 1972); the other two returned in July 1975, on exactly the 10th anniversary of the project.

Many of the original residents who had participated in the project were still there, and they were unfailingly warm and cooperative when we reappeared. Other residents who in 1965 had not been pleased with the project were courteous and cooperative the second time around. Several newcomers to Amelia County who now played significant roles in the life there were generous in sharing their time and information with us. From the people we visited, the facilities we attended, and the demographic and health data available through Virginia State and county agencies, we were able to gain some insight into the nature and extent of the changes that had taken place in Amelia County from the activist sixties to the stolid seventies.

In this report we describe the general sociological, political, and economic background of Amelia County, the health project set up there in 1965, the health scene in 1975, and our conclusions as to whether the 1965 project had a significant impact.

Amelia County in the Sixties

Southside, the part of Virginia where Amelia County is located, is predominantly rural, poor, and conservative and has a high black population. In the early sixties, political initiatives were practically unknown in the region. Almost complete segregation of the races and an inferior status for blacks had long been maintained. Local government was merely custodial. Little money was spent at the local level for public services such as schools, welfare, and health care. Agriculture was the population's main source of income, and dollar incomes well below the poverty level were common, patricularly among blacks. The region was economically stagnant and did not show the population growth characteristic of the State as a whole in the sixties; nor has it shown such growth subsequently.

Amelia County is located 35 miles southwest of Richmond. Its area is 366 square miles. The county population in the sixties was about 7,800 (it still is); 52 percent of the people were black and 48 percent white, a ratio that is now reversed. The county government was administered by a board of supervisors, composed of one representative elected from each of the three magisterial districts. The three-member school board was elected on a similar basis. In 1960, 33 percent of the voting age blacks were registered, compared with 88 percent of the voting age whites. There were no black elected officials and indeed no black officials of any kind in the county then except for the black county agent and the black home demonstration agent of the then still segregated U.S. Department of Agriculture Extension Program.

Agriculture was and is the principal industry of the county, consisting of dairy and livestock production and the cultivation of tobacco and feed grain. The median family income in 1959 was $2,715. For blacks, it was $1,866; for whites, almost double that. More than one quarter of the black families had annual incomes below $1,000, and more than three quarters had annual incomes below $3,000. Fifty-six percent of the housing of blacks lacked some or all

plumbing facilities. Among blacks 25 years old and older in 1960, the median number of school years completed was 6. The comparable figures for whites were not a great deal better—7 years for men and 8 years for women. In the school year 1963–64, the public school enrollment was 58 percent black and 47 percent white.

Virginia State Department of Health statistics for 1963 showed a birth rate of 25.3 per 1,000 for blacks in Amelia, compared with 15.3 for whites. In Virginia as a whole, the rates were 45 per 1,000 for blacks and 24 per 1,000 for whites. For the United States, the comparable rates in 1963 were 41.7 for blacks and 22.3 for whites. The population of the county is too small for significant annual figures on infant mortality; in the adjacent and larger Nottoway and Prince Edward Counties, however, the infant mortality rate among blacks was several times that for whites. The median age at death for blacks in Virginia in 1963 was 60.7 years; for whites, 68.8 years. In Amelia, 57 percent of the black births in 1963 took place outside a hospital, and at only one in six was a physician in attendance. For whites, 19 percent of the 1963 births were outside a hospital, of which 9 in 10 were attended by a physician. For Virginia as a whole in 1963, 87 percent of the births to black mothers were attended by a physician; for the United States in the same year, almost 90 percent of such births were attended by a physician.

Thus, many indicators make clear that Amelia County was a relatively poor area and that blacks there were particularly disadvantaged.

Health Care in Amelia in the Sixties

Two physicians, both white general practitioners, had offices in Amelia County at the time of our project. One was partially retired following a heart attack and made no house calls, took no new patients, and held office hours only in the morning. Both physicians saw black as well as white patients. Some Amelia blacks saw physicians in adjacent counties or even in Richmond, but most seemed to rely on the two physicians practicing in the county.

There was, and still is, no hospital in Amelia. The closest was at Farmville, in Prince Edward County. A 100-bed institution, then segregated, it enjoyed little esteem among the Amelia blacks whom we met. They preferred the hospital facilities at the Medical College of Virginia in Richmond.

Public health activity was centered in the Amelia health clinic. This was a unit of the Virginia State Department of Health and was nominally under the charge of one of its regional health officers. This officer was responsible for several counties, however, and spent only one half-day a week in Amelia. The clinic was thus in effect run by the full-time public health nurse. Although the clinic was administratively connected to the State health department, the nurse's salary and part of the clinic's operating costs were paid by the county.

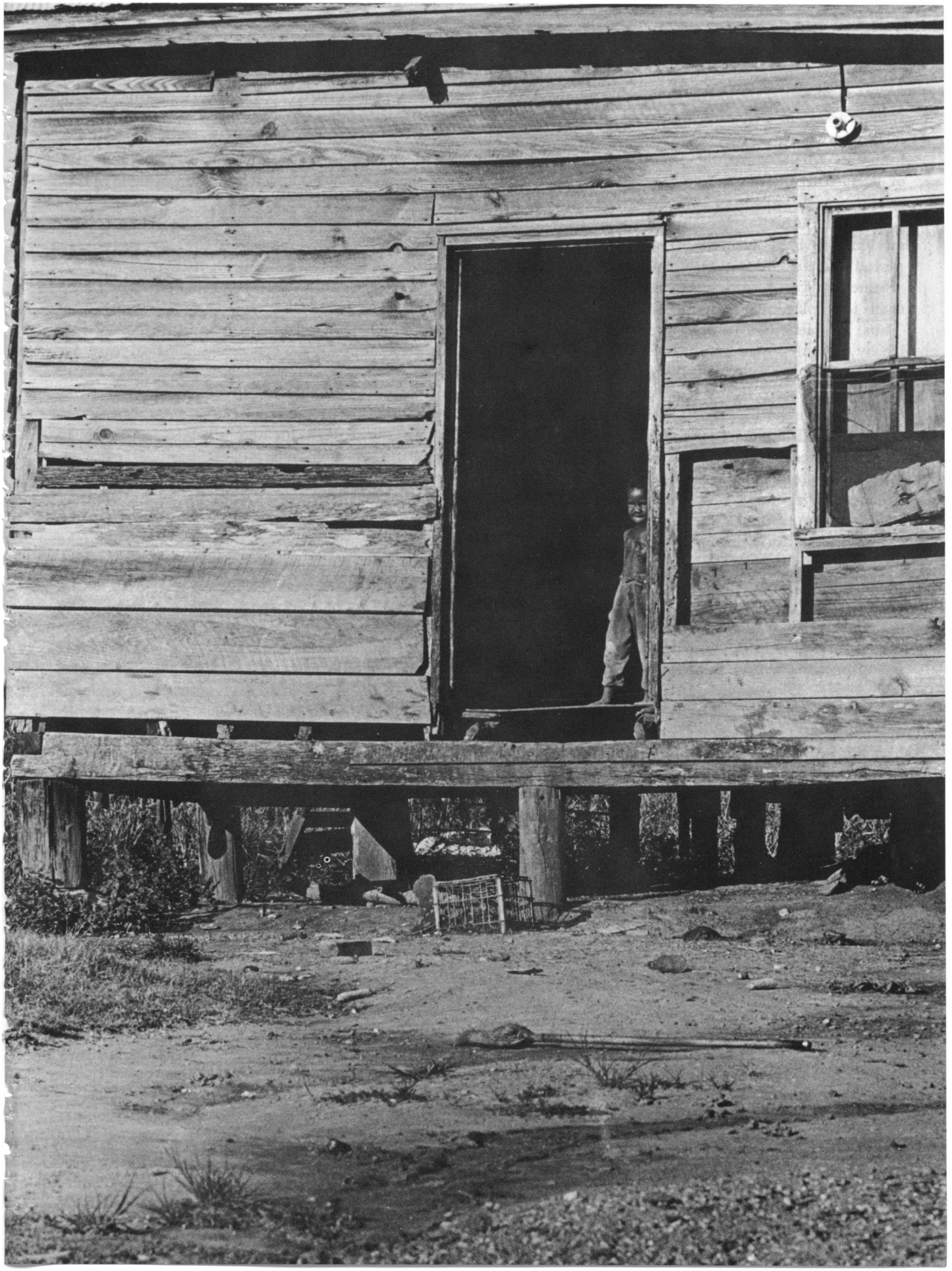
The services offered at the clinic came chiefly under the heading of maternal and child health and were generally available only to the medically indigent. There were prenatal and postnatal clinics and a family planning program. Basic immunizations were given to county children. In addition to the nurse, the clinics were staffed by the health officer and the two local practitioners.

Besides her duties at the clinic, the nurse made home visits to newborns in the county, conducted vision testing on children entering school, and carried on health education in talks to groups around the county. A feeling that was rather frequently expressed in that period, and that we heard again in 1975, was that the nurse was less caring for the blacks who needed her aid than for the whites. Our own direct experiences with her, however, at least in the more recent period, were reassuring.

As a special service, the State health department would pay the bill for a medically indigent maternity patient who required hospital care. Such patients had to be certified as appropriate candidates (by a local physician or more commonly by the health clinic), since hospitalization for childbirth was not routine for low-income blacks.

The health clinic was the certifying and referring agency for the various specialty clinics available to medically indigent children under the Federal Crippled Children's Program. These specialty clinics were held in large centers, away from Amelia, usually in Richmond. Tuberculosis screening was carried on at the Amelia health clinic by a State health department mobile X-ray unit that visited Amelia periodically.

Various other State health department programs provided patient services, but not in Amelia: four mental health and mental retardation clinics under the Federal Maternal and Child Health program; a tuberculosis sanatorium where patients paid according to their ability; a free 3-day diagnostic hospitalization for persons referred by the local clinic who were suspected of having cancer; and physical therapy for medically indigent patients with stroke. The State health department also provided a variety of vaccines, drugs, and laboratory tests to physicians and clinics under a number of special programs.



It was apparent that as a rule State and locally supported health services in Amelia County and elsewhere in Virginia deliberately left the system of private practice of medicine undisturbed. Thus, most health services were available only to the medically indigent. Furthermore, these services were generally of a narrowly defined type, aimed at a particular medical condition rather than at the total care of the patient. In Amelia, for instance, the only direct services provided were for women in the perinatal period and for children requiring immunization.

State services were designed to supplement rather than to replace the care of the family physician. Thus, a patient had to be referred to the State service by a local physician or clinic and would return to the referring agent for followup supervision. Such State services were in any case usually located some distance from the local community. The two private general practitioners in Amelia were the only sources of overall medical supervision for an individual or a family. The outpatient department of the Medical College of Virginia was 35 miles away, in Richmond. (Besides, the emphasis there was on specialty care rather than on total care.)

There were other State health department services that could have been made available to local communities such as Amelia. These services included dental care for medically indigent children and for chronically ill adults; nutritional and dietary consultation; cooperation in the establishment of venereal disease clinics; and assistance in establishing heart disease study clinics, tumor clinics, general medical clinics, and home care programs. Such services, however, could only become available upon the initiative and with the financial support of the locality. And in a poor county like Amelia, governed by conservative white officials, there was little willingness to take the initiative or expend funds for programs such as these. For example, during the summer of 1965, several hundred Amelia blacks signed a petition calling for the county's participation in the State health department's program of dental care for medically indigent children. The State would have shared the cost with the county on an 80-percent-State-to-20-percent-county basis. The need could not have been greater. Nevertheless, the Amelia board of supervisors turned the request down.

Most blacks in Amelia did not have enough money to purchase health care in a fee-for-service private practice system. Many had no cash at all most of the time. The two practitioners in the community presumably accepted late payment or payment in kind and undoubtedly gave some service free. We did not hear of sick people being turned away from the physician's door for lack of money. Nevertheless, inability to pay clearly acted as a deterrent to some blacks who might otherwise have sought care for a variety of health conditions. Inability to pay was doubtless a factor in the extremely infrequent contacts with physicians reported to us by Amelia blacks. (The next section gives results of a health survey undertaken in Amelia as part of the 1965 project.)

MCHR-Presbyterian Church Project

The Medical Committee for Human Rights (MCHR) was founded in 1964 during the well-known civil rights summer project in Mississippi. Its aims at that time were to provide emergency medical care for southern blacks and civil rights workers and also, in the form of a sympathetic "medical presence," to serve as an ally of the people who were directly engaged in the struggle for human rights for blacks. In the spring of 1965, the MCHR national office received a request from the Board of National Missions of the United Presbyterian Church USA to conduct a health project in Amelia County and invited the Metropolitan Washington MCHR chapter to take this on. The Washington chapter, 135 miles away, was the closest one to Amelia.

In the spring of 1965, the Washington MCHR was only a few months old. The main arena for its activity until then had been Selma, Ala., where it had planned and executed emergency medical measures for the civil rights marches there. The national MCHR organization had by 1965 begun to encourage constructive longer term local activities as well. The Washington group had considered some possibilities for activities but as yet had no local program in operation or even in preparation. A proposal that the chapter accept the job in Amelia was greeted with enthusiasm, both because of the merits of the Presbyterian Church program itself and because of the opportunity it gave chapter members to get involved in the civil rights and health reform struggles as quickly as possible.

The United Presbyterian Church USA is represented in Amelia County by the Zion Hill Church, which has a black congregation and minister. Its minister in 1965 was Rev. Robert Craghead, whose main impact on the county since his arrival there 1 or 2 years earlier had been in the sphere of political and social action, rather than in the more traditional pastoral activities. Through Craghead's efforts, a number of civil rights and political action efforts were planned for Amelia for the summer of 1965. Craghead believed that a health project would be a

valuable element in the summer program and sought help from the national office of his church to implement this project. The United Presbyterian Church USA in turn contacted the Medical Committee for Human Rights for aid with the project.

When the Washington MCHR chapter agreed to take over the Amelia project, only 5 weeks remained before activities were scheduled to begin. Much planning for the summer health project thus had to be compressed into a short period. The main responsibility for the project was assumed by four MCHR physicians, three of whom were then working at the National Institutes of Health (NIH) and one at Howard Medical School. Intensive efforts were devoted to organization of the health project, recruitment of personnel to work in it, arranging for equipment and supplies, and visiting Amelia itself to gather impressions and information that would guide further planning. In many instances, the planners took time, both formally and informally, from their regular work duties. D.S. made 11 round trips between Washington and Amelia from mid-May to the end of July 1965 and 2 more in October. The cost of time and travel for project planning and implementation was borne in all cases by the participants themselves. All participants were unpaid volunteers.

Recruitment of the volunteer personnel for the project was especially time consuming. Letters were sent to a variety of health organizations and institutions, notices were posted, telephone calls were made to friends and acquaintances, and many personal contacts were made. Not only physicians were sought, but also nurses, social workers, laboratory technicians, medical students, and indeed anyone able and willing to help. The press of time and the unwillingness of many of the volunteers to make specific advance commitments left the project planners with the recurring task of making last-minute arrangements for staffing various project activities all during the summer.

Twenty-one physicians participated in the Amelia project: 16 from the National Institutes of Health and 1 each from the Group Health Association, the U.S. Children's Bureau, the Veterans Administration Hospital in the District of Columbia, Howard University Medical School, and private practice. Nine were MCHR members. Most were trained in internal medicine, three were pediatricians, one was a pediatric surgeon, and one was an orthopedic surgeon. (In the screening clinic we sponsored, the only division of labor was between pediatricians and the rest of the physicians; where possible, children, especially the very young, were seen by pediatricians. Besides internists and pediatricians, the only specialists we deliberately tried to recruit were ophthalmologists for glaucoma screening. Eventually we had the services for this purpose of a fourth-year medical student who had had special training as a clinical clerk in the Howard University Medical School's Department of Ophthalmology.)

There were 11 medical students in the project, all but 1 between their third and fourth years. Four nurses from the Washington, D.C., area participated, as did five social workers, a laboratory technician from NIH, and several wives, husbands, and friends of participants who did not have health-related skills but helped in administering survey questions, directing traffic at the clinic, keeping records in order, and performing countless other tasks. About 15 teenage boys and girls and their chaperons from a church-affiliated service group spent 2 days at the clinic, and there was a group of people from the Presbyterian Interracial Council. Two women from New York, one a physiologist and the other a music teacher, who had been recruited through the national MCHR office, did invaluable preparatory work before and during the screening clinic. In all, close to 60 adults from the Washington area, plus the teenage group, contributed their efforts to the program.

Extremely valuable help was available also from people residing in and near Amelia. For their contribution, Craghead was chiefly responsible. Several black nurses and two laboratory technicians from the Piedmont Tuberculosis Sanitarium in nearby Burkeville worked at the screening clinic. Two of the summer civil rights workers were nursing students. Many Amelia residents, mostly from Craghead's congregation, helped by providing food and places to sleep for project participants from Washington, D.C., as well as furniture for the clinic. The civil rights and political action project workers (mostly college students who had come to Amelia for the summer) encouraged residents to attend the clinic and provided transportation for many of them.

In view of the existing sociopolitical and health-care arrangements in Amelia, we decided to mount a three-part health program, consisting of community health education, a survey of health practices and needs, and a screening clinic. The community health education effort was informal and unsystematic. MCHR workers made a series of weekend visits to Amelia, where they met with individuals or small groups in people's homes or at the Presbyterian Church. At these meetings an attempt was made to discern the health priorities and needs of the people of Amelia and to discuss what might be done to meet them. The MCHR group hoped to stimulate

the formation of a citizens health council among the blacks, an ongoing group that would identify health needs and see that corrective steps were taken. This outcome, however, did not occur. MCHR workers also explicitly suggested that county residents might organize to arrange convenient transportation to Richmond for those who needed to attend outpatient clinics there. (It had been a frequent practice among Amelia blacks for a person with a car to transport those who had none, for a price. This transport in any case was an entirely casual affair. The bus service to Richmond was twice a day, with only one stop in Amelia County, at the Amelia courthouse. The 35-mile trip was thus a difficult undertaking for the many blacks who did not own a car.) No followup action was taken on the suggestion about transportation either.

In the survey of health practices and needs, the questionnaire used was one compiled by the Washington, D.C., Medical Committee for Human Rights from previously published survey materials. The questions were mainly concerned with the illness experience of family members and their past use of health services. MCHR and civil rights project workers administered the questionnaire door to door, reaching approximately 17 percent of the black population of Amelia. Informal observations also were made as to the number of rooms and the plumbing arrangements in the homes visited. The conclusions drawn from this effort were that the utilization by Amelia blacks of physicians, dentists, hospitals, and other health resources was much lower than national averages (as determined by the National Health Survey of the Public Health Service); also, that there was considerable crowding in many black households and that bathroom facilities were primitive. The survey, however, was designed and carried out without input from people trained in survey work, and in retrospect we realized that the conclusions were valid only in a qualitative way. Furthermore, because neither MCHR nor the Amelia blacks had good connections with the local or State power structure, the survey results were not effectively plugged into a potential channel for followup action.

The MCHR screening clinic was held on the grounds of the black Zion Hill Presbyterian Church in Amelia, in tents and in suitable parts of the church building itself. (There had been unsuccessful attempts previously to arrange for use of the county health clinic building or the black elementary school for this purpose.) Appropriate measures were taken to insure the patient's privacy. The examination included a checklist history (reviewed with the patient by the physician); a microhematocrit determination; measurements of urine pH, glucose, blood, and protein by reagent strip; a determination of blood serology and of 2-hour postprandial blood glucose (these samples were sent to the State laboratory at Richmond); a visual acuity measurement with the Titmus tester; a measurement of intraocular tension; blood pressure measurement; an electrocardiogram for selected patients; a Papanicolaou smear of the cervix in appropriate cases; and a general physical examination, including the rectum and pelvis unless contraindicated.

The results of the examination (except certain laboratory results that were not available until a later date) were discussed with each patient on the same day by the examining physician, who advised on necessary followup steps. Later each patient received a letter, which varied in format according to whether the results of the examination were within the normal range, the patient had an abnormality for which he was already under care, or the patient had an abnormality for which he was not under care and for which appropriate followup by a physician was recommended. Those in the last group were invited to return to the church on a weekend in October, when two MCHR physicians would be available to discuss their health problems and help arrange for followup care.

In all, 821 persons were examined, 674 of whom were residents of Amelia. All but two were black. There was an appreciable rate of impaired vision and of hypertension. Anemia was also prevalent.

The observation that deserves the most emphasis is that 266 persons, or 34.5 percent of those to whom letters were sent, merited a recommendation to see a physician for further investigation or treatment of a medical condition. Such a recommendation implied that the patient was not under care for that condition at the time the clinic was held. Many of the patients who were not receiving care had impaired vision or hypertension. A wide variety of sporadic conditions, of course, were noted in addition, such as heart murmurs in a few children, a pelvic mass in a middle-aged woman, and an occasional positive result on a test for occult blood in the stool. The recommendation for physician followup was not made casually or for trivial indications. Thus, the fact that 34.5 percent of the persons examined received this recommendation indicates that there was a substantial amount of unmet health need in this group. This result is consistent with the striking underuse of health services reported by this population.

During preliminary visits to Amelia in 1965, the MCHR planners had met a number of people, both black and white, who were active in community affairs. In this way they learned about the social and political developments then current in Amelia, particularly how whites and blacks had been responding to the recently court-ordered school integration and to the establishment of an anti-poverty planning agency. The MCHR planners found that a good deal of moderate-versus-conservative polarization had taken place, both between the races and within the white community itself. Given this climate, the MCHR workers tried to present themselves in a conciliatory way. A health program, they believed, was relatively nonpolitical and noncontroversial, and it was hoped that whites, as well as blacks, would participate, at least in the screening clinic. In fact, the MCHR planners were courteously, if not cordially, received by most Amelia whites they visited. Cooperation, however, did not extend beyond this. Sympathetic whites were apparently unwilling to jeopardize their standing in the community by identifying themselves with a program connected with the activist part of the black community and with civil rights efforts. Only two white persons attended the screening clinic, and they were from an adjacent county.

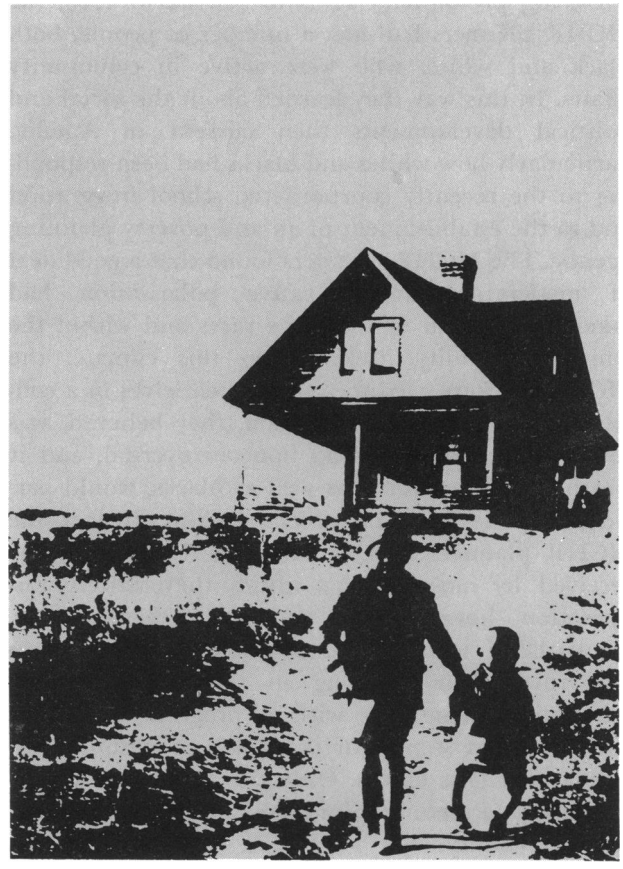
Amelia County in the Seventies

By the seventies, political, social, and economic conditions in Amelia had changed for the better, although as the following examples suggest, progress and stasis still could be observed side by side.

- Fifty percent of the qualified black voters and 90 percent of the white were registered to vote—up from 33 percent of blacks and 88 percent of whites in the 1960s (percentages calculated from figures supplied by the Voter Education Project, Atlanta, Ga., the State Board of Elections, Richmond, Va., and the Amelia County NAACP (National Association of Colored People)). The Fourth Congressional District, of which Amelia is a part, was represented by a conservative Republican, but it had sent a racially integrated delegation to the Democratic National Convention in 1972 and was expected to do so again in 1976. (It did.) The county government was now administered by a five-member board of supervisors, and—a milestone in the political life of the county— one of them was black.
- Two of the five members of the school board were black. The schools, which were making a first tentative move toward desegregation when we were there in 1965, became integrated in 1971. (Although integration had proceeded smoothly, a continuing source of abrasion and tension in the county was the existence of the private academy for white children whose parents resisted their attendance at integrated schools. The children of the supervisor of the Amelia County school system and of two members of the school board were enrolled in the academy.) Amelia was somewhat below the State mean in total cost and local expenditure per pupil in the public schools; the proportion of its high school graduates who went on to college was only about one-third of that for Virginia as a whole (*19*).
- Economic improvement and increased per capita income in the State had not been accompanied by any shift in Amelia's position of relative poverty. Agriculture was still the principal source of livelihood. Efforts had been made to introduce heavy industry, but they were resisted by white residents, who feared that the quality of life in the county might change. Linked to this objection was the expectation that industrialization might accelerate a reverse migration of blacks from the city to rural areas and bring with it a population explosion.
- The churches were still segregated. Exploratory attempts nationally at cooperation by the two sectors of the Presbyterian Church had not reduced the separateness of the two Presbyterian churches in Amelia. In the sixties, the black United Presbyterian congregation (Zion Hill Presbyterian Church) had enjoyed the militant leadership of Craghead, as mentioned earlier. Since his departure, however, the lay leadership of the congregation had been less activist. Neverthless, the church's minister in 1975, Rev. B. H. Craig, was a man of dedication and social awareness. Despite having part-time status and a less supportive congregation than in Craghead's time, he continued to reach beyond the church into the community.
- One of the vehicles for change with which Craig worked was the Amelia County Assembly. This citizens organization, together with its counterparts in adjacent counties, had young black leaders, lofty social goals, and a touch of political pragmatism. It addressed a wide range of issues, including veterans' rights, local school affairs, employment, health care, and national political issues (taxes, budget, Supreme Court actions) that affected the lives of the poor. The Epistle, a free monthly newspaper sponsored by the local Methodist Church, reported on the activities of the assemblies and informed, advised, and exhorted its readership.
- An interesting new force in the county in the seventies was the Amelia Bulletin Monitor. This free

weekly newspaper was published by a young woman whose intelligence, energy, and commitment to county betterment had won wide, nonpartisan admiration.

Socioeconomic conditions in Amelia had improved since the sixties, and yet, to quote a NAACP officer who had worked with the health project in 1965, "Things haven't changed in 10 years as much as we'd hoped." Further change seemed increasingly difficult. Particularly affecting was the plight of black activists in the county, who felt isolated, not only from the white community but also from fellow blacks, many of whom were apathetic about efforts to mobilize voters, to improve economic conditions, or to pressure the board of supervisors (which still split four to one on social welfare questions) to petition for, or even to accept, the county's fair share of Federal funding.



Health Care in the Seventies

In an article on the First National Conference on Rural America in the May 1975 issue of the Nation's Health, the following question and answer appeared:

Question: What has 60 million people, a mean income of only 73% of the national mean, some 19,000 physicians fewer than would constitute a barely acceptable minimum, and enough misconceptions revolving about it to successfully mask the extent of its problems?

Answer: Rural America.

The annual statistical report of the Virginia State Department of Health for 1973 indicated improvement in the health status of Amelia County residents. The population remained at about 7,900. The black to white ratio in the population was 48 to 52, a reversal of the ratio of 10 years earlier. This change probably reflected a greater outmigration of blacks than whites from the county during this period. Births per 1,000 population, both for blacks (14.5) and for whites (12.5), and infant mortality rates (33 per 1,000 live births for blacks and 17 for whites) were sharply down from the sixties. Black births outside a hospital dropped from 57 percent in 1960 to 5 percent in 1973. White births were 100 percent in a hospital.

Medicare and Medicaid contributed to the improvement of health care in Amelia, but not enough. As was true in many other parts of the country, these new sources of financing had not increased the number of health professionals. There were still only two physicians in private practice in Amelia; one was a newcomer from South America who believed that health care was a right, not a privilege, and tried to conduct his practice accordingly. This physician was tremendously appreciated by the many people who told us about him. It was clear, however, that Medicare and Medicaid regulations imposed restrictions that inhibited people from seeking care, even from this physician.

Actually, until 1975, Virginia had been one of the more liberal southern States in terms of the services it permitted under Medicaid (*20*). But effective January 1975, many drugs were eliminated from the list of those originally covered; small charges were set for prescriptions, eyeglasses, and eyeglass repair; and most medical supplies and equipment were no longer covered. The Medicaid guidelines were again being revised at the time we visited the county social services office in July 1975. A case then being processed was cited as an example of the effect of existing regulations. A family of three with an annual income of $3,000 had to pay the first $100 of its medical expenses out of pocket, after which Medicaid assistance would be available for 3 months. If another illness should strike in the fourth month, the first $100 would again have to be paid by the family. The social services department made an earnest effort to draw on

the resources of specialized agencies (for eye care, lung diseases, and cancer, for example) to meet this family's medical needs. But an annual income not higher than $2,900 for a family of three or total dependence on welfare were the prerequisites for comprehensive Medicaid coverage. Regulations concerning ownership of land or other property also prevented some marginally subsistent people from qualifying for needed health and social services.

The details of the system did not seem as important as the persistent perception among county residents that "old people can't afford to be sick" and "working people don't get the care they need" and the conservatism of the local government that limited the services that with Federal and State help might have been provided. On the other hand, some of our informants pointed out that facilities and services were available which, allegedly because of ignorance or indifference, were underused.

Preventive services and many kinds of direct care were still being offered or arranged for by the county health department. The Amelia health clinic was now staffed by two full-time nurses and a half-time assistant. The regularly scheduled clinics for maternity care, child health, and family planning were attended by physicians. The Bureau of Child Health of the State department of health conducted comprehensive Crippled Children and Child Development clinics, which although they were not available locally, were attended by eligible patients for whom the public health nurses had made appropriate referrals and arrangement. Blood pressure monitoring and hypertension prevention comprised a new program at the clinic. A school nurse also now provided valuable liaison between the schools and the county health department.

A serious dearth of dental services existed in 1975, not only in Amelia but in the entire State, where according to the 1973 annual statistical report of the Virginia State Department of Health, "much remains to be accomplished before the overall problem of dental health can be contained." Mental health services and health education were also in short supply.

This glance at health care in Amelia County suggests, as a more thorough look would also document (*21*), a degree of fragmentation that could be corrected by local application of the Federal Comprehensive Health Services Program. A comprehensive health center that treated "the patient and his health needs in a total manner, not separating medical needs from social and environmental factors" (*20*), would be welcomed by many residents of Amelia—professional and nonprofessional, political and nonpolitical, members of organizations and individuals. It is one of the goals of the Amelia County Assembly and the assemblies of neighboring counties.

A pertinent "social factor" surfaced as a community issue at the time of our July 1975 visit. The county board of supervisors for many months had been resisting a proposal for a federally funded nutrition program for the elderly. The four-to-one white majority blocked its adoption, ostensibly for the reason that it was not needed, but for the underlying reason (as perceived by the black community) that it would have been administered by the Central Piedmont Action Council, an agency that the board did not conrol. The December 1975 issue of the local Methodist Church newspaper, the Epistle, reported that "for the second time in 5 months the Amelia County Board of Supervisors has refused to allow the Senior Citizens Nutrition Program into the county. The nutrition program . . . [would use] federal funds to provide 3 meals a week to people 60 or older . . . the program would not cost Amelia anything, other than providing a building or space for the program . . ." The black member of the board "said he would like to take the Supervisors for a ride through the county so he could show them the conditions some of the elderly are living in and how they would benefit from the free meals."

The same issue of the Epistle included items about food stamp eligibility, hypertension and sickle cell anemia clinics, dangerous toys, and possible health hazards of a nuclear reactor plant and a report to the council for the county assemblies on "efforts to get doctors to come to rural areas." There was little question that health was an issue in the county and the region and that local government was seen as an adversary by those who were working for change.

In a careful study in 1944 entiled "The Health and Medical-Care Situation in Rural Virginia" (*22*), Tate described the conditions that existed then in rural Virginia and proposed a program for change. In 1975, the First National Conference on Rural America affirmed that such a program had not been implemented in rural America. Nor has it been implemented in Amelia County.

Discussion

What can be learned from this retrospective view of the Amelia health program and Amelia County 10 years after the project of the Medical Committee for Human Rights? One point that has become clear over time is that a considerable discrepancy

existed between the stated objectives of the health program and the unspoken agenda of those who carried it out. The stated objectives mainly had to do with the stimulation of broad community change in Amelia, particularly in relation to meeting the needs of black people. In other words, the objectives that were stated were in terms of the needs of Amelia. The unspoken agenda had to do with the needs of the MCHR physicians and other health workers. Much of the impetus that led the physicians and other workers to embark on the program was derived from a need to feel they were part of the civil rights struggle and were involved in making changes in a real-world community. Such duality is not necessarily negative or counterproductive, although it can be if it propels people into activities not well gauged to meet a community's needs. In the case of the MCHR group working in Amelia, its members had an interesting and informative experience, and the needs of the members were satisfactorily met. Whether the needs of the Amelia County community, however, were as well met is another matter.

The basic undertaking in Amelia in the summer of 1965 was to stimulate political consciousness and community organization among the local blacks and to make the power structure more responsive to the black community's need for improved human services. As a component of the overall summer effort, a health program was seen as contributing to that undertaking as well as being useful in its own right. Nevertheless, a health program must consist of concrete health-related activities. In addition to the informal health education effort, the MCHR planners chose to carry out two rather formal, well-defined activities—a questionnaire survey and a screening clinic. These are both exacting technical tasks, and if they are to be done at all, they demand a considerable investment of time and effort in their planning and execution, as well as in obtaining equipment, supplies, space, and so forth (especially for the clinic). Furthermore, if the tasks are to be performed, they need to be performed well; no health professionals involved would feel comfortable otherwise. These considerable demands are made regardless of the political context in which the health activities are carried out.

The MCHR group did not anticipate the extent of these demands, and its failure to do so had two consequences. First, the survey and the clinic were not conducted in all respects according to the best professional standards. The group was a great distance from its home base, expert consultation was lacking, and the volunteers were a shifting and somewhat motley group—all factors that took a toll. Second, the project as a whole diverted the time and energy of the MCHR group from activities that might have been more directly useful politically.

Did the health survey and the screening clinic accomplish any useful ends in themselves? In the case of the survey, the results were not usable in any quantitative sense because of deficiencies in the survey's design and execution. Thus, the data could not be compared meaningfully with survey results for other groups; nor could they serve as a baseline for comparison with figures obtained at a later date. In additon, the MCHR group did not have the time or the auspices needed to establish working ties with responsible health officials and others who might have made some practical use of the survey results.

The screening clinic did uncover a good deal of untreated illness, as we have already noted. MCHR did what it could to encourage followup care, both at the time of the clinic and by letters and return visits afterwards. Nevertheless, it was the clear impression of the MCHR physicians that most of the people with untreated abnormalities did not receive satisfactory ongoing care for them. The failure to receive such care was due to a number of factors: lack of access, cost, patient apathy, and so forth. Not being on the scene in Amelia continuously, the physicians were less effective in this effort than they might otherwise have been. Some people did receive care, and some of those treated undoubtedly benefited in reduced morbidity or prolonged life. During our return visits, a dozen of such instances were pointed out to us either by the patients themselves or their families, for instance, of hypertension controlled or glaucoma successfully treated—conditions that otherwise would have continued to be neglected but for the health project. Still, it is far from clear that the benefit matched the cost.

What about the more fundamental objectives of community organization and political change? Many Amelia blacks told the MCHR workers that the workers' interest and presence in Amelia had made a deep impression on the people there and given a boost to black morale. But the outcome in the sense of direct and concrete benefits must be counted as nil. In the immediate aftermath of the health program and the other summer efforts, political alignments and political structures in Amelia were unchanged. Divisions over school integration persisted. Health services were unchanged. As mentioned earlier, in the very summer of our project, the Amelia board of supervisors turned down a request, brought

by black residents at the urging of civil rights workers, for Amelia to participate in a county-State program of dental care for the poor sponsored by the State health department. No citizens' health council was formed. Transportation to the Richmond hospital was no better. (Ironically, the rescue squad that now transported Amelia residents to the Richmond hospital still determinedly excluded blacks from its membership, although it offered its services impartially.)

Were there indirect, longer-term benefits from the health program? From the perspective of 10 years, we could see progress in the political system, in the expansion of county health services, and in the voluntary organization of Amelia County residents around a variety of social welfare issues, including health. We do not know whether these changes derived in any degree from the summer project, or whether they would have occurred anyway with the progress of the times. That kind of question is difficult to answer at best, and in the present case, there was no ongoing contact between the Medical Committee for Human Rights and Amelia that might have provided some perception of the ingredients of change.

We must conclude therefore that neither in health terms, nor in sociopolitical terms, did the summer health program produce benefits commensurate with the investments it required. Such a program is most likely to have useful outcomes if it is planned and carried out largely by people who know the community well, are involved with it on a long-term basis, and optimally are themselves members of it. In contrast, the MCHR effort was short term and the work of outsiders. Such an undertaking can be worthwhile if it is aimed at providing carefully planned concrete services and at the same time fits coherently into a locally based long-term effort (*16, 23*). In Amelia, however, there was not much of an ongoing local base for such an undertaking. There was only Craghead and a handful of other black activists; no true community organization had yet been established. In these circumstances, the MCHR group might better have stayed at home and turned to longer term involvement in the health problems of the Washington, D.C., area. (A 1975 issue of the Health/PAC Bulletin provides a critical review of MCHR activities and policies (*24*).)

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