NEIGHBORHOOD HEALTH CENTERS: AN

ANALYSIS OF COLLECTIVE ACTION

Dixie Wiles Ray

Submitted to the faculty of the University Graduate School
in partial fulfillment of the requirements
for the degree
Doctor of Philosophy
in the Department of Political Science
Indiana University

March 1992

Accepted by the Graduate Faculty, Indiana University, in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Elinor Ostrom
Elinor Ostrom, Ph.D., Chair

Russell Hanson
Russell Hanson, Ph.D.

Doctoral
 Committee

Robert Huckfeldt
Robert Huckfeldt, Ph.D.

December 19, 1991

Roger B. Parks
Roger Parks, Ph.D.

ii

111

PREFACE

Having been a faculty member in a school of nursing for a number of years, I am sometimes questioned about the relationship of political science and health. Although eminently obvious to me, study of the development and operation of neighborhood health centers is an opportunity to shed some light on this relationship for others.

For over twenty years, neighborhood health centers have been a positive feature of life in the United States. The centers were developed as a result of collective action by neighborhood groups and have remained controlled by community residents. Decisions to be made for health centers are complex, technical, involve large sums of money, and are a challenge for professional administrators. Some theories would suggest that the centers would never have been started, let alone continued as a focus of community collective action. How then, have untrained community residents been able to meet this challenge? This is the question I will address.

My efforts in completing this dissertation were supported by a number of people. My deepest admiration and appreciation goes to health center board members, staff, other interested folk for doing what they did to start and operate health centers and for digging in their files and minds for the information I needed. Their willingness to share information far exceeded my

Dixie Wiles Ray NEIGHBORHOOD

HEALTH CENTERS: AN ANALYSIS OF

COLLECTIVE ACTION

This dissertation examines the factors that contributed to
successful collective action in establishing and operating
neighborhood health centers in low resource urban areas.
Persons involved with the health centers over a twenty year
period were identified and focused in depth interviews
conducted. Historic documents, including correspondence,
reports, minutes and newspaper articles were reviewed.
Explanation of collective action in the low resource
neighborhoods required the integration resource
mobilization theory with expansions of Olson's logic of
collective action. A tentative set of conditions necessary
for such actions includes: a highly valued collective
good; neighborhood mechanisms for interaction and
communication among most members; consensus about the end
to be achieved; leadership that is willing to use other
than institutionally approved tactics; residents willing to
put aside differences for the collective interests; loyalty
and commitment to the neighborhood; and, leaders who work
with members to develop social capital.

Doctoral Committee

Elinor Ostrom _Robert Huckfeldt_

Russell L. Hanson _Roger B. Parks_

vi

TABLE OF CONTENTS

FIGURES AND TABLES

CHAPTER ONE

HEALTH CARE IN URBAN AREAS

1

CHAPTER ONE HEALTH CARE IN

URBAN AREAS

> "The hospital was the only source of health
> care for the poor. And the greatest way that
> people got medical care from around here was going
> to the hospital, and of course that took a day.
> Patients had to stay there all day long to be seen
> - they took your clothes at 8 and gave them back
> to you at 5.
>
> And some people just would not go to the
> hospital. So, they organized. And they talked to
> everybody about the health center every time they
> saw them. And when we got the building, people
> from all the churches and the neighborhood
> organization helped. The Catholic youth helped
> clean the outside of the building, and other
> community members painted and cleaned inside."
> (Thelma Tookes, 1988)

The late 1960s were periods of great changes for urban

areas. Large numbers of the poor and minorities had

migrated to the cities in search of employment and a

better life. Middle class residents perceived this large

influx of people different than themselves as contributing

to a decline in the value of their city neighborhoods,

making them a less desirable place to live. Residents

with sufficient economic resources to support a move

migrated to the suburbs, abandoning the inner city

neighborhoods to those with fewer resources. The

residents left behind were less able to support the

neighborhood commercial areas, and essential services and

stores began to close or move to more lucrative areas,

contributing to a downward economic cycle in the

neighborhoods. Essential services such as medical care
provided by private physicians were not long in following
the more affluent population to the suburbs. Physicians
who remained in the neighborhoods were primarily elderly
and nearing retirement.

Attempts made by neighborhood groups to recruit new
physicians to inner city neighborhoods were rarely
successful. When the physicians visited the neighborhoods
they saw empty stores, old buildings in deteriorating
conditions, and people who probably did not have the money
to pay their doctor bills. Because of the poor conditions
of the neighborhood, the physician would be unlikely to
attract patients from outside the area.

Obtaining medical care became a major problem for
those persons remaining in inner city neighborhoods.
People with low incomes have greater health care needs
than those with more money (Syme & Berkman, 1976). Yet,
because of their lack of economic resources, the
neighborhoods were unable to attract to the area the
health care services that were needed by the population.
Physicians believed, perhaps rightly so, that sufficient
income could not be generated to justify their practicing
in the areas.

Private physicians are not the only source of care in
cities. Two sources usually available in large cities are
the public health department clinics and the public

hospital, but each of these is less than satisfactory in providing primary health care services for the people. Historically, public health clinics have been limited to a variety of preventive, social welfare, and nutritional services. It was a matter of deliberate policy that they gave no medical care for illness. Physicians have long supported health department activities that were complementary to private medical practice, but opposed activities that were competitive. Thus, physicians supported health department activities related to communicable disease research and laboratories, but objected to provision of health services to persons who were ill. Dispensaries for the poor were perceived as taking money out of the private practitioner's pocket (Starr, 1982).

Traditionally, public hospitals have been another source of medical care for the poor. However, the circumstances under which the care is delivered can inhibit use of the services. Transportation difficulties, block appointments (scheduling all the patients to be seen in the morning at 8 a.m, for example), long waiting times, seeing a different health care provider each time, and treatment without concern for the patient's dignity were frequent issues at public hospitals. At the same time there was a decline in the quality of services at public hospitals (Hollister, Kramer, & Bellin, 1974). Although

the circumstances were unacceptable to the people, a lack of resources, power as well as money, made it difficult for them to make demands on local governments and institutions to alter the situation.

A POTENTIAL SOLUTION

One alternative available to the people during the late '60s was the development of a neighborhood health center. Health centers built on the strengths of a neighborhood, the people themselves. Legitimization by the Federal government facilitated the acquisition of other resources.

From their beginning, neighborhood health centers integrated the concept of collective action. As prescribed by the enabling legislation, the centers were to be initiated and operated by citizen dominated boards. A network of neighborhood health centers has been developed in the United States since 1965. They were originally funded by the Office of Economic Opportunity (OEO) as a part of the "War on Poverty". Although neighborhood health centers first appeared in the United States in 1910, the centers proposed in the sixties had expectations in addition to medical care. The OEO health centers were conceived to not only increase the availability, accessibility and quality of medical care in low income areas, but also to give the poor "an assured

5

role in the design and control of their own health services" (Geiger, 1984) . The centers were to "emphasize the formation of community health associations..." (Feingold, 1970) .

Neighborhood health centers were to be reform organizations, and represented a national experiment designed to solve problems associated with poverty and inequality in accessibility and availability of medical care (Hessler & Beavert, 1982). It was believed that the improvement of health care services could be used as a point of entry for broad social changes. The philosophy underlying the development of health centers was one of empowerment. Poverty was conceptualized as a matter of deprivation and powerlessness. To address poverty, programs had to be concerned with how the poor could become powerful. From their beginning, neighborhood health centers integrated the concept of collective action. Over the years, the level of citizen participation in health center activities and operation has varied from tokenism to full participation.

 Three community based elements were included in the original neighborhood health center model: community health services; community economic development; and community participation (Sardell, 1982). Community health services were intended to decentralize care and bring it closer to the people. Neighborhood health centers were to

6

serve defined geographic areas and provide integrated treatment, both curative and preventive, and offer outreach programs with local residents trained as family health workers. Provision of jobs for local residents as family health workers and in other staff positions was viewed as having the potential to increase the economic well-being of the area.

Funding agencies for neighborhood health centers had a strong theoretical commitment to citizen participation. However, the first grants for neighborhood health centers went to hospitals or medical schools and these institutions developed consumer advisory boards. In 1969, the Watts Health Center in California was the first center to request transfer of the funding to the board (Sardell, 1982). Demands for increased consumer control came from the local health center boards and other 0E0 centers soon made similar requests.

As mentioned above, the initial grantees were medical schools, teaching hospitals, or health departments, and struggles occurred over the meaning of community participation and/or control. However, the 0E0 policies stressed the role of the community organization in organizing and operating the neighborhood health center. Medical schools had difficulties sharing management with community residents and phased out of these operations. Hospitals, on the other hand, have continued a

relationship with neighborhood health centers, partly because the centers provide an additional pool of patients to fill empty beds. However, the hospitals reduced their participation in initiating new centers; the field was left open for an increase in community initiated centers. By 1971, 59 percent of the health center grants went to new health corporations as administering agencies for health centers - community groups in partnership with health providers (Geiger, 1984).

Although the neighborhood health center concept provided an opportunity for neighborhood residents to develop health services that were appropriate for themselves, many barriers were encountered in completing this process. Opposition to neighborhood health centers had been anticipated and indeed arose from several sources. Members of the established health care delivery system were expected to protest that they were already providing necessary services, and to object to the distribution of funds to other organizations to provide health care services. Because the centers were addressing multiple problems and suggesting redistribution of power in the community, additional opposition was anticipated from other existing sources of power in the community.

Conflicts also occurred within the neighborhood health center organizations. Health professionals were accustomed to relative autonomy in decision making and did

not realize that community residents' views of programs might differ. In addition, community residents on the boards represented different interests and viewpoints. Not all community residents shared the same goals for the centers.

The lack of permanent governmental commitment to the centers was predicted to have dire consequences for the future of neighborhood health centers (Alford, 1975). The government funding agencies expected the centers to become increasingly self-sufficient, yet the programs were aimed at the poor and those persons without health insurance or other funds to pay for health care. Historically, the neighborhood population had been unable to provide sufficient income for a private physician, but now was expected to develop sufficient monetary support for a health center.

Changes in federal regulation also affected the growth of neighborhood health centers and the services provided. In 1973, the programs were shifted at the federal level from OEO to the Bureau of Community Health Services in the Department of Health, Education, and Welfare (now called Department of Health and Human Services, DHHS). This was a change from an agency interested in innovative projects aimed at altering community power structures to one more interested in providing health care. As time has passed, the NHCs have

reverted more to provision of traditional medical
services.

When new legislation, the Community Health Center Act
(PL 94-63), was enacted in 1975, neighborhood health
centers were renamed Community Health Centers (CHCs) and
the level of services required to be available was reduced
to those considered as "primary care" (see Appendix).
Preventive, outreach, and less traditional services were
considered supplemental and not to be supported by
federal financing. Although the new legislation had a
negative impact on service, the same legislation required
each community health center to have a consumer dominated
board as the grantee for federal funds for the center. The
majority of the board members were to be "consumers" and
"represent the individuals being served by the centers".
Interpretations of the definition of "consumer members"
have varied in the ensuing years with increasingly
stringent interpretations being made by federal
government agency officials.

Hospitals that operated neighborhood health centers
have objected to the requirements for a "policy" consumer
board, preferring to have instead an advisory board
(Sardell, 1982). Legislation was introduced supporting
their position but drew opposition from the American
Medical Association (AMA) as well as from advocates for
consumer run centers. The AMA opposition occurred because

of concern over hospital based group practice and the long run impact on the private practice of medicine. The legislation was defeated and the involvement of neighborhood residents in the management of the centers has remained as an essential feature.

The Reagan administration attacked the fundamental principles that gave rise to health care reform. Questions were raised about the role of the federal government in the provision of health care for the poor. Although some funding cuts occurred during the Reagan years, Congress has been responsive to pressures from neighborhood health center organizations and continues to provide financial support.

FACING THE CHALLENGE

In 1968, the structural mechanisms were in place for the development of consumer dominated neighborhood health centers. But would neighborhood folk be able to gather the resources required for development and operation of health centers? Starting a neighborhood health center would require action by the people in the neighborhood. They would have to expend a great deal of time and effort. Resources needed included leadership, money, labor, and even a place to hold meetings. A neighborhood health center would be an alternative health care system and

challenge the existing system; would they have the
strength to do this?

A casual reading of the literature on collective
action suggests that individuals, especially those with
limited resources, would have a difficult time acting
collectively to obtain health services in the
neighborhood. The neighborhood folk would perceive
themselves as lacking the financial resources, skills, and
knowledge needed and acquiring these resources would
require more of their time than was available. They would
leave the work for those with more adequate resources.

However, neighborhood health centers were developed
throughout the country and several hundred continue in
operation. The questions to be answered are:

1. Why were the people in some particular
    neighborhoods, in the face of adverse
    conditions, able to develop a collective
    solution to the problem of supplying health
    care?

2. What modifications of current theories are
    required to include the cases presented?

When considering how to study these questions, it is
immediately apparent that there are no aggregate data
available which might provide the answers.   One method
that can be used to obtain the needed information is the
case study, which provides in depth process information

12

about collective action related to neighborhood health centers. Yin (1984) has defined the case study as an empirical inquiry that "investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used" (pp. 48-49). The embedded, multiple case study design can be used to examine neighborhoods in one city where the residents, through collective action, developed and continue to operate neighborhood health centers. The cases (neighborhoods) are selected so that they either predict similar results or produce contrary results for predictable reasons. In-depth interviews with community residents who were active in the neighborhood health center board through the years provide both historic and current information about collective action in the neighborhoods. Results of this study will be used to build on existing frameworks and to raise questions about existing theories.

SETTING OF THE ACTION

The three neighborhoods to be studied are located in Indianapolis which is the capital of Indiana. The city was established in 1824 and its growth was facilitated by its site along the National Road and by the development of the railroads. The railroads played a vital part in the

development of neighborhoods, as residential areas
developed to accommodate the workmen and their families
attracted by employment opportunities with the railroad
companies and the industries that followed. These
neighborhoods later were part of the ring of residential
areas around the downtown that were allowed to deteriorate
as more prosperous residents moved further away from the
center of the city.

Center Township is, appropriately, the center of the
city and contains the downtown area and many of the oldest
buildings, both residential and commercial, and the three
neighborhoods of interest. The residential areas around
the downtown share in common problems related to being in
the outward bound path from the center of the city and
being part of the industrial ring that circled the
central city when manufacturing dominated the economy of
the city. The neighborhoods have vacant factories and
commercial buildings, as well as residential areas. Some
neighborhoods have experienced gentrification, while
others continue to deteriorate.

The neighborhoods studied are: Barrington,
SouthEastside, and NearEastside (see Figure 1 - Map of
Indianapolis showing the location of the neighborhoods).
The health center in each of the areas is funded by a mix
of federal and local dollars. Differences among the
neighborhoods include demographic characteristics, the way
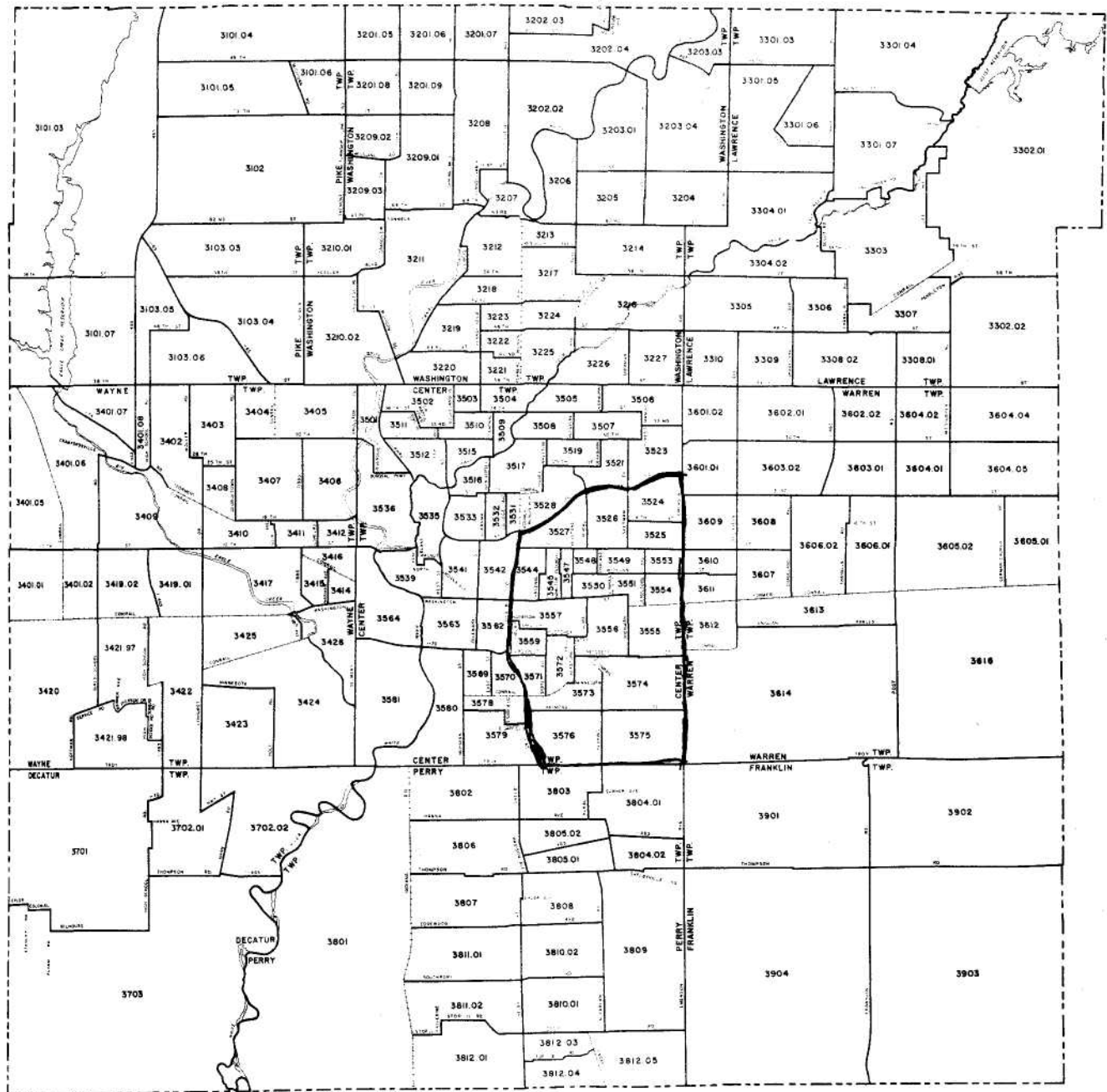
MARION COUNTY
1990 CENSUS TRACTS

Figure 1. City of Indianapolis.

N

in which the health centers were started, the manner in which they are operated, and the level of collective action related to other issues within the neighborhood.

Statistical data for the neighborhoods as defined by the neighborhood health centers are shown in Tables 1.1 and 1.2. A brief anecdotal sketch of each neighborhood and the health center located there are included to facilitate understanding of the environment in which the neighborhood health centers operate.

Table 1.1
Neighborhood Statistics

Area	% Below Poverty	Unemployment Level	Infant Mortality Rate(a)
Barrington	16	6.4	13.4
NearEastside	36	(b)	14.7
SouthEastside	20	8.0	15.6
Marion County	11	5.2	14.2
Indiana	10	6.1	11.0

a.   Number of infant deaths (less than 1 year old) per 1,000 live births.

b.   Data not available at this time.

Note: Data are from 1980 U.S. Census, Indiana Vital Statistics, 1985, and the Marion County Health Department.

Table 1.2
Educational Characteristics

Neighborhood	0-8th Grade	1-3yrs High School	High School Graduate	Some College
Barrington	24%	28%	37%	11%
NearEastside	28%	29%	31%	13%
SouthEastside	29%	28%	33%	10%
Marion County	15%	18%	31%	30%
Indiana	16%	17%	42%	25%

Note: Data are from 1980 U.S. Census.

SouthEastside Neighborhood

The SouthEastside is a low income, predominantly white neighborhood with a substantial proportion of Appalachians. Gentrification has come only recently to this neighborhood and has created divisiveness among the residents, pitting old residents against new. This neighborhood lies just to the south of the center of the city and as downtown development has moved south, so have the young professionals. Housing in the area is very old, with many houses dating to the early twentieth century. In contrast to the NearEastside area, more of the houses are workmen's cottages and are appealing to single persons or childless families.

17

The commercial district in Fountain Square continues to meet many of the needs of local residents of the neighborhood and, recently, some new establishments have appeared, including antique shops and a "fern bar". Many churches are in the neighborhood and have played an active role in addressing community problems. A wide variety of social programs are available through a multiservice center and other agencies. Barrington Neighborhood

The Barrington neighborhood is in the southeastern part of Center Township, just north of the independent city of Beech Grove, and has industrial areas in several locations in the neighborhood. Commercial areas are scattered throughout the neighborhood, but in some cases are abandoned and serve only to attract litter. Although this area has long been part of Indianapolis, on occasion one may still see a horse in a field or a privy in a back yard. City services and utilities were very slow in coming to this area.

Most of the housing in the area has been built since 1930, although there are some units that are clearly older than this.   The area has historically housed working-class people and continues to do so in the single family homes. Several public housing projects are located in the neighborhood.

For decades there have been small groups of black working- class families living in the Barrington neighborhood. Black residents are scattered throughout the larger neighborhood in smaller subcommunities of several blocks. Construction of the housing projects in the neighborhood attracted a population (primarily black at first) that was very different from other neighborhood residents. The new residents were most often from the north side of town and not employed. Long time black residents continue to have great pride in their community, but have been willing to take on the concerns of the residents of the housing projects, recognizing the newcomers' problems as being neighborhood problems.

NearEastside Neighborhood

The NearEastside neighborhood is immediately east of the center of the city, bounded on two sides by interstate highways. Some industries have located on the fringes of the area and occasionally appear within the neighborhood. The main commercial area is on a major thoroughfare cutting through the area from east to west. This area contains most services that are needed by residents as well as a considerable number of antique stores. The presence of the commercial area is important because large numbers of residents do not own automobiles.

Almost all the housing in the area was built more than 50 years ago and is in varying states of repair.

19

Many of the homes are quite large and have gone through devolution into apartments and, through gentrification, back in to single family homes. One section of the neighborhood, Woodruff Place, is considered a fashionable place for young professionals to live. The population of the neighborhood, as a whole, is predominantly white and about one fourth of the persons have Appalachian backgrounds.

THE PLAN OF THE REMAINDER OF THE STUDY Considering the difficulty anticipated for low resource communities to act collectively, how can their success be explained? In the second chapter I will review and consider theoretical explanations for collective action, or in many cases, inaction. The completeness of these theories for use in explaining collective action by neighborhood residents seeking to obtain valued goods in their neighborhoods will be considered.

In chapters three, four, and five case studies of the three neighborhoods are presented. The three cases were selected because they had been involved in the process of starting and operating neighborhood health centers and had sufficient informants and documents to describe the process through which the neighborhoods organized, found resources, and developed and operated health centers.

In chapter six, each of the case studies will be examined to identify the factors that contributed to their successes and impeded their progress. Next, I will look across the cases to identify common themes. Linkages will be made to theoretical work, gaps in theory identified, and modifications of theories suggested.

CHAPTER TWO

THE COLLECTIVE ACTION DILEMMA

Chapter Two The Collective

Action Dilemma

> "The 'logic of collective inaction' may
> be overcome if residents can share the
> costs of collective goods and pool
> their resources so that the expected
> benefits of cooperative effort outweigh
> both the costs of participation and the
> net benefits of inaction for an
> adequate number of residents." (Rich,
> 1980a)

In Chapter One I characterized the attempt to provide and
maintain a health center in a poor neighborhood as a
problem of collective action. And yet, health care
services have many attributes associated with private
goods. Obtaining private goods normally does not require
collective action because entrepreneurs are motivated to
supply private goods to residents of a neighborhood.   The
problem becomes one of collective action because market
mechanisms frequently do not work very effectively to
provide continued medical services of a high quality to
residents of inner-city, poor neighborhoods. The failure
of the market to provide health services accessible to
neighborhood residents necessitates that they
reconceptualize health services. Neighborhood residents
attempting to start neighborhood health centers have
redefined health care availability of services as a
collective good. Most of the residents have been affected

by the loss of private medical care for the neighborhood and the residents share interests in the services a health center can provide. If they can pool their resources through an organization, they may be able to secure health services in their neighborhood and at a low cost.

Neighborhood health center proponents <u>intend</u> for the services to be a collective good. In the case of neighborhood health centers, the intent is to remove many of the barriers to access to service and to provide services to all who request them. To qualify for services, patients must present themselves in an orderly and nonthreatening manner. Costs to the patients are determined according to their ability to pay. The centers provide care to individuals at a cost they can afford. For many persons they represent the only financially accessible source of care. Because they are located physically within the neighborhood, the services are also geographically accessible. This institutional form for providing and maintaining a neighborhood health center is characterized as providing a facility available to all within a region. Since no one can be excluded from the benefits, strong incentives exist to let others do all the hard work of organizing and maintaining the facility.

A public good is defined as "one which is not subject to exclusion and is subject to jointness in its consumption or use" (Ostrom & Ostrom, 1978).   Exclusion

24

is the denial of goods or services unless the potential users meet the terms and conditions of the vendor. Jointness of use implies nonsubtractibility, that is, the use of a good by one person does not interfere with its use by others. Although being used by one person, the good is still available for use by others. However, most joint consumption goods are partially subtractible, that is, one person's use of a good subtracts in part from its use by others.

Few "pure" public goods exist. Public and private goods are at opposite ends of a continuum and many goods are not at the endpoints, but will be closer to one end than the other. Their placement on that continuum will vary depending both on the nature of the goods and the arrangements for the service.

Examples of public goods that meet both the criteria of joint consumption and nonsubtractibility are fire prevention and mosquito control. In their usual form these services are provided to everyone in a location whether they desire the services or not. It should be noted that these collective goods are public only for the defined neighborhoods toward which the services are directed. Fire prevention services of a particular fire department are usually limited to specific geographic boundaries. Within an area they may be provided as a

public good. Outside those boundaries they may operate as either a public or private good.

Health center services are partially subtractible. Health centers have the capacity to see a finite number of clients at a particular time, and a high rate of demand may create congested waiting rooms and long waiting times. However, services can be increased by increasing staff, staying open longer hours or more days of the week up to full use of the facility at all reasonable times if the high demands continue.

Positive externalities occur because everyone in the neighborhood, whether they use the services or not, benefits when the health of the population is improved. The health center enhances the neighborhood generally and makes it a better place to live. The facility is an ever present symbol of successful action by neighborhood residents.

Having observed that collective action has taken place among residents in neighborhoods with low resources, what are the theoretical explanations for the action? Why do individuals, particularly poor individuals, expend considerable resources to organize themselves to provide and maintain neighborhood health centers is an important policy question for which we do not have a clear theoretical answer. Some theorists do not expect such activities to occur unless individuals

receive selective benefits or punishments or are coerced
into participating. The clearest statement of this
theoretical position was made by Mancur Olson (1965) in
The Logic of Collective Action.

PRODUCTION OF COLLECTIVE GOODS

Olson (1965) rejects what he refers to as "the
pluralistic view that private organizations spring up
voluntarily and spontaneously in response to the needs,
beliefs, and interests of the various groups" (p.130).
Sometimes a group must create a new formal organization
before it can obtain the collective good. The costs of
establishing the organization must be added to the costs
of provision of the good and the first units of the
collective good will be more expensive than later units.
The increased costs of the first units may be higher than
individuals are willing to pay and the required
organization may never be developed.

Olson asserts there is a basic, logical tension
between the interests of the individual and those of the
group.[1] In large groups there will be little incentive
for the individual members to contribute toward the
provision of a collective good. Because of the size of
the group, the effect of a single individual's failure to
contribute will be minimal and likely to be unnoticed.
Unless there are benefits obtainable only through

contributing, few incentives exist for members of large groups to contribute. The rational, self-interested individual will decide that it is in his interest to sit back and let others do the work since he will share in the benefits of a collective good even without having contributed to it. If many people take this position, the collective good may never be pursued.

Olson suggests that collectivities that offer only public goods (those not exclusive to contributors) inevitably suffer from a "free rider" problem. Since the costs of production are likely to exceed most members' personal benefits, no incentive exists for most members to bear the cost of production; hence, suboptimal (or no) amounts of the good will be produced. Olson argues that unless coercion or selective incentives (private goods) are also supplied to members, collective objectives will seldom be obtained.

Olson developed his theory in relation to large existing organizations (e.g., professional organizations, unions). For intermediate groups, which do not have so many members that any one member will notice whether any other member is or is not helping to provide the collective good and no single member gets a share of the benefit sufficient to give him an incentive to provide the good himself, collective action may or may not take place.

Olson also acknowledged that the behavior of small groups interested in collective behavior is complex and that the production of outcomes by such groups is affected by institutional or procedural arrangements. Small groups provide opportunities for the operation of social incentives, such as prestige, respect, and friendship. Face-to-face interaction among small group members may generate social pressures to contribute to the collective good. Olson focused on the large organizations and did not extend his model to smaller, face-to-face organizations. While Olson's theory provides some guidance to an explanation of the development of the health centers, one must look to other theories to explain the outcomes among the low resource neighborhoods.

OTHER THEORETICAL DEVELOPMENTS

Other complementary theorizing about incentives for participation in organizational activities occurred prior to the publication of Olson's work. Clark and Wilson (1961) hypothesized that three kinds of incentives for contribution of activity operate in organizations: material incentives, solidary incentives, and purposive incentives. The first of these, the material incentives, are the tangible, monetary benefits of economic rationality addressed later by Olson, while the solidary and purposive incentives are intangible. Solidary

29

incentives are derived primarily from the act of
associating and include rewards such as socializing,
congeniality, sense of membership and identification, and
status. Solidary incentives tend to be independent of the
ends of the association. Groups that use such incentives
tend to pursue noncontroversial goals. Purposive
incentives, on the other hand, derive in main from the
stated ends of the association or "issues" in support of
causes or principles. Activists contribute their time and
efforts because they believe in the goals and methods of
the organization. This type of incentive occurs most
often during the formative stages, when resources are
scarce or during crises. Collective Action in a Social
Context

Hardin (1982) proposes that collective action must be
examined within the context of other exchange
relationships. Individuals do not make decisions to
participate in collective action based solely on the
merits of the given action, but viewed in relation to
other interactions with the group. Hardin develops
complex arguments related to the success of collective
action. He modifies rationality from its more narrow
economic definition to being "efficient in seeking one's
self interest" (p. 10). Concepts discussed by Hardin are
of particular interest here are: asymmetry and
extrarational behavior.

Although all group members in Olson's model are
assumed to have identical interests in the collective
good, some members may value the good more than other
members. Such different valuations may produce a small
subset of group members that values the good very highly.
Asymmetries can occur in four different ways: (1) between
costs and benefits; (2) in demand for group goods; (3) in
the content of the goods; and, (4) between gains and
losses. Hardin concludes that asymmetric communities may
be far more successful in generating the political
activity to bring about a supply of a host of collective
goods. Because of the differences, the community can
generate subgroups each of which values highly a specific
good and is willing to engage in collective political
action to obtain the good.

Another refinement of Olson's work suggested by
Hardin identifies the role of extrarational motivations in
collective action for which the benefit to the individual
may not be calculated. Extrarational motivations include
moral motivations, desire for self-development through
participation, and ignorance and misunderstanding. Moral
motivations have an important role where selective
incentives are difficult to provide. In these situations,
the collective good, as well as being valued by the
individual, will be perceived as required by a sense of
justice or fairness. When organizations depend on such

moral contributions, they must pursue relevant goals which,
when attained, create a more just or fair situation.
Leaders play an important role in contributing to the
production of collective goods by persons guided by
extrarational motivations. Resource Mobilization Theory

Resource mobilization theory offers another view of the
factors that contribute to successful collective action.
Although addressed to social movements, the theory has
implications for collective action in general, especially
among low resource groups. Resource mobilization theory
emphasizes the importance of structural factors such as the
availability of resources to a collectivity and the
position of individuals in social networks, and stresses
the rationality of participation in social movements.
These theorists see social movements as extensions of
institutionalized actions, in which previously unorganized
groups organize against institutional elites or represent
the interests of groups excluded from the polity. Over
time, long term changes in group resources, organization,
and collective opportunities emerge from changes in power
relations or structural conflicts of interest.

Within this framework Jenkins (1983) argues that
 formal organizations create order out of chaos and
 increase the likelihood that groups of low income

32

individuals will achieve their collective action goals. In particular, an entrepreneurial model, in which the major focus is the availability of resources (especially cadres[2] and organizing facilities) appears most relevant for deprived groups and broad disorganized collectivities. The entrepreneur works to link collective interests and the pooled resources needed to achieve those interests. Other factors identified by Jenkins as part of resource mobilization theory are existing groups, resources, incentives, group structure, and the external environment. Each of these is discussed briefly below.

Collective action is sometimes perceived as the response to a crisis. However, a prompt response to a crisis presupposes the existence of a resourceful, organized group. Groups that have a strong collective identity and high levels of interaction among group members are more readily mobilized. Groups whose members have their strongest ties to outsiders are less likely to mobilize. Still unanswered by resource mobilization theory is the question: If collective interests are emergent, how are such collective identities formed?

No one crucial resource can be identified, but a certain store of resources must be developed before groups can be successful in their action. The necessary resources vary from group to group and deficits in one dimension might be offset by surpluses in other

33

dimensions. For example, having an experienced organizer in the community may offset the lack of monetary resources among community members. Mobilization to action depends on resources, a process to pool resources and direct these towards change (organizational goal), and the extent to which outsiders increase the pool of resources. Resources may be tangible (money, facilities, means of communication) or intangible (human assets such as organizing and legal skills, and unspecialized labor of supporters). Resources also come from outside the community from individuals with discretionary time schedules and income (such as professionals and college students) or liberal institutions with "slack" resources. In social movements, entrepreneurs have posed their membership appeals in terms of "collective evils" rather than in terms of the selective benefits available to members. Moralistic concerns are considered to be the primary incentive. Study of successful movements suggests they overcome the potential problems of organizing around collective material benefits and free riding by offering the collective incentives of group solidarity and commitment to moral purpose. The major task in mobilization, then, is to generate solidarity and moral commitments to the group in whose name movements act. The effectiveness of incentives varies for different class groups. Middle and upper class groups are more receptive

to purposive incentives, while less secure, lower-class groups respond to selective incentives and collective solidarity.

The organizational structure of the group affects its ability to mobilize "grass roots" participation. While bureaucratic structures provide technical expertise and coordination essential in institutional change efforts, they are less effective in mobilization than decentralized structures that maximize personal transformation. Decentralized structures mobilize "grass roots" participation and insure group maintenance, but often at the cost of strategic effectiveness.

Events in the larger political environment shape the outcomes of movements. The positions taken by political elites and the support or opposition of other organizations affect outcomes. When the political system is not functioning well, it is more receptive to social reform. Routine shifts in political power create opportunities for access by groups with new ideas.

THEORY APPLIED

Since its publication, Olson's work has greatly influenced the study of collective action. Although other authors may not always agree with Olson's conclusions, the basic premises are seldom challenged. Instead the emphasis has been on extending and modifying Olson's

model to apply to collective action instances in addition to those he examined. Some of the theorists utilize concepts from other theories and have asserted that additional factors beyond those considered by Olson (for example, incentives other than economic ones) must be taken into account in explaining when individuals will engage in collective action. The works of major contributors to the extension of Olson's theory are described below.

One of the shortcomings of Olson's work is that he did not examine how groups are first organized, but assumed an on-going system. Salisbury (1969) offers one explanation of the initiation of new groups in his exchange theory of interest groups. He presents the notion of entrepreneurs who provide the capital necessary for the development of a group. This differs from Olson's "privileged group" in which one individual may value the good so highly that he will work alone to see that the collective good is provided. Salisbury emphasizes the formation of the group that will work to obtain the good. In his framework, the entrepreneurial role is generically identical with that of group leader. In other words, a leader of a group is an entrepreneur who must be providing benefits continually to members in exchange for their membership and activity in the organization. To ensure their continued efforts, group organizers (entrepreneurs)

may be paid or receive sufficient expressive value. Other, older organizations may provide a source of entrepreneurs and capital. Early organizations may serve as training grounds for later entrepreneurs or provide examples of successful organizations.

Capital for these entrepreneurs may be their own time and energy as an individual interested in organizing the group. The entrepreneur must develop benefits for potential participants. Salisbury utilizes the material, expressive [3], and solidary incentives developed by Clark and Wilson (1961). The price of the benefits is membership in the organization. The organization formed articulates the interest, and by organizing its adherents provides more effective bargaining power vis-a-vis other groups.

Problems with the assumption of perfect rationality in decisions to participate in collective action have been identified by Marsh (1976). He suggests that individuals do not have access to complete information about the situations they face. Nor do individuals always attend to all the information they have. Decision making situations are reconstructed both in terms of information and individual preferences, resulting in the use of an "imperfect" rationality. His study of the decisions of firms to join an industrial organization suggests that firms joined even though they were aware that collective

benefits were available to them without membership. In
addition, it was not clear that the influence exerted by
the industrial organization was always to the benefit of
some of the participating firms. Instead the benefits
accrued to certain sections of the actual and the eligible
membership. Although member firms were aware of this,
they continued their membership. The costs of membership
were perceived as low and the benefits of membership
difficult to calculate.

If change is to occur, capital is necessary. Lachmann
(1978) develops the notion of capital as a complementarity
of various assets. Although some money is required, other
capital resources are also needed and may include
institutions, organizations, and skills. The composition
of the capital stock is of greater importance than the
amount of capital, although the amount must be sufficient
for the task. Assets are complementary, and various
combinations of assets may be made to meet the demands of
the situation. Change does not take place in a vacuum,
but within a dynamic environment. The specific nature of
the environment may contain elements that eliminate the
need for certain resources.

Entrepreneurs carry a heavy responsibility in
Lachmann's argument, because they provide the creative
energy and develop the diverse capital resources.
Expectations play a major role in the use of capital,

especially for the entrepreneur. Expectations reflect a
continuous process of assessment of cumulative experience
and revision based on new experiences. Interpretation of
the situation, determination that there is a problem to be
addressed, and preceding to make plans to resolve the
problem are functions of expectations.

Moe (1980) attempted to develop a formal structure
that better reflects the substance of interest group
membership and organizations. He extended the scope of
the analysis beyond the relationship between collective
goods and individual incentives to take into account dues,
selective incentives, and collective goods simultaneously.
Moe's expanded model of group membership went beyond
economic motivation for group membership and took into
account group goals, ideology, feelings of responsibility,
sense of fairness, social pressures, and other purposive
and solidary dimensions of motivation. Values and
perceptions are not considered fixed, but amenable to
alteration by communications from peers and group leaders.
Moe relaxed Olson's assumption of perfect information,
developing first a general economic model on this
foundation, and then dropping the assumption of economic
self-interest and allowing for noneconomic inducements. It
is this latter model that contributes most to
understanding of the complexity of motivations for group
membership.

Moe introduced into his model the noneconomic
incentives identified by Clark and Wilson (1961),
recognizing the solidary and purposive (as well as
economic) incentives that they maintain affect individual
decisions to participate in groups. While solidary
incentives produce social benefits (for example,
friendship, esteem) to participants, failure to
participate may result in social costs such as ostracism
or loss of status. Purposive incentives contain a
political element because they derive from the support of
causes, principles, or ends valued by the individual. The
individual may feel a responsibility to contribute and
enjoy benefits by the expression of his support. The
model developed by Moe explained the logical role of
solidary and purposive dimensions of motivation, but left
to empirical research the question of the extent of the
value of these factors in field settings.

   Gamson (1990), in a study of 53 social protest
organizations in the United States since 1800, argues that
persuasion is a major factor in motivating people to
participate. Claims of loyalty to the group or
neighborhood can be used to convince people to
participate, not just the material incentives claimed by
theories based on economic rationality. He describes the
importance of the free-rider problem and selective
incentives as exaggerated. Gamson argues that broadening

40

the selective incentives argument beyond tangible goods
and services to a variety of "soft" incentives reduces the
concept to a useless tautology. The concept must be
limited to the specific goods or services that an
organization provides as inducements. Instead, commitment
and self sacrifice help to explain the continued
participation of individuals in collective actions that
others may view as hopeless.

Gamson presents data that refute the pluralists'
contention that only those groups which use
institutionally provided means will be successful in
political influence. His findings suggest, on the
contrary, that willingness to break rules and to use
noninstitutionalized means —-to use disruption as a
strategy of influence — leads to success in collective
action (p.156) .

Rich (1980b) suggests the use of a political-economy
approach to the study of neighborhood organizations. This
approach treats neighborhood organizations as
institutional mechanisms for coordinating collective
effort in pursuit of group goals. Residents of urban
neighborhoods have many common interests because of their
residential location.

Building on Olson's theory, Rich develops a
theoretical framework for the study of neighborhood
organizations. A key factor in an individual's

calculations regarding participation is how adequate he or she considers the group's resources are to produce the desired goods. When residents perceive the neighborhood resources as low relative to the perceived cost of desired goods, they have little reason to expect a collective goods payoff. If they think the ratio of resources to demands is high, residents will have reason to anticipate successful collective action. Problematic is that low resource neighborhoods often have the highest demand for collective goods, and are the least likely to be able to generate collective action.

Other factors may increase the likelihood of collective action. Although voluntary associations lack formal coercive power, they may have access to informal coercive power.[4] However, the latter type of power is less effective because it requires greater energy to maintain coercive mechanisms and may distract energy from the collective action itself.

Leadership is another key factor identified by Rich. People are always needed who take the actions which make it possible for neighborhood residents to work collectively.[5] Individuals who are willing to become leaders of organizations in areas with a low ratio of resources to demands will generally be motivated by deference values. Because most individuals in poor neighborhoods have low resources, leadership will require

greater sacrifices than in more affluent neighborhoods. Such high demands may lead to instability in leadership, because no one individual is able to meet the demands of leadership over a long period of time. Government can contribute to the likelihood of collective action in low resource neighborhoods by implementing policies that produce incentives for neighborhood residents to participate in the activities or pay for staff to assist them.

The effect of feelings of responsibility on contributions to collective action was examined by Fleishman (1980). The sense of responsibility appears to depend on the perception that one's actions have a significant or unique causal impact on another's welfare. Fleishman considers voluntary contributions to a public good as instances of helping behavior. He hypothesizes that when others are contributing sufficient resources, little incentive exists to contribute. However, when a deficit is clearly evident, responsibility motivates people to contribute.

Empirical tests have supported Fleishman's hypothesis and are congruent with Olson's discussion of the role of group size. When the feasibility of successful accomplishment was low, subjects felt little responsibility to contribute. Group size was related to feelings of responsibility. Incentives to contribute were

low when the group was either too small to be able to accomplish the task, or so large that a single contributor perceived his contribution as not having a noticeable effect. The greatest level of individual effort may occur at intermediate levels of group size. The tests also addressed the effect of the size of the loss to others if the public good was not provided. Results suggested that payoffs for others and their needs were considered in the decision to contribute to the public good.

Fleishman concluded that people do not behave as a strict interpretation of the free-rider hypothesis would suggest. Instead, collective action is an instance of helping behavior, and decisions to engage in collective action are mediated by a sense of personal responsibility to help others.

Of particular relevance, because he studied the initiation of neighborhood organizations, is the work by Henig (1982). Based on his study of urban neighborhoods and their mobilization efforts, he maintains that no one theory explains collective mobilization. Although pluralism, the rational choice perspective, and the radical perspective each offer methodological or conceptual insights that help expand understanding of the conditions under which neighborhoods do or do not act collectively, each approach varies in its assumptions and conclusions regarding collective action. Henig attempts

44

to construct an integrated framework that utilizes the contributions of these theoretical perspectives and identifies the conditions that affect the possibility of collective action. While behavior is affected by factors in the local and situational environment, the broader environment sets the parameters within which collective behavior occurs.

Henig identifies conversion factors that either propel or impede neighborhood residents in their mobilization efforts.   He categorizes them as contextual or situational (see Table 2.1). Contextual factors are the relatively fixed attributes of the social, political, and economic environment and are the givens of any particular action. Situational factors refer to the perceptions and behavior of the actors whose interactions combine to directly form the response. Henig's formulation places the particular instance of collective action in context and suggests that explanations of successes or failures must consider both the situation and the context.

Henig recognizes that people have more than one source of motivation. He proposes that people are more likely to act rationally when stakes are high and when their behavior is considered over the long run. Response to social or collective interest is most likely to occur under conditions of cultural homogeneity, shared

Table 2.1

Variables Influencing Neighborhood Mobilization

	Neighborhood	Extraneighhborhood
		National and State
Contextual	Neighborhood wealth Residential stability Homogeneity Population loss and decline Preexisting organizations	Political traditions Political culture Laws and constitution Dominant ideology Distribution of wealth
		City
Situational	Leadership Mobilization strategies (such as utilization of selective incentives)	Local decision-making structure Officials' strategies of implementation Officials' commitment to own plans

(Henig, 1982, p. 64)

conditions and experiences based on concepts of loyalty, comradeship, and public responsibility.

Working within the resource mobilization theory framework, Klandermans (1984) introduces expectations as a factor influencing the decision to participate. The goals of social movements are "collective goods"; however, individuals have to decide to participate at a point when they do not know whether others will participate. Expectations occur in the areas of others' participation, importance of their contribution, and value of benefits.

46

To develop these expectations, an individual must have knowledge about the collective good and its implications.

Klandermans argues that motivation to participate has three bases: collective motives, social motives, and reward motives. The <u>collective motive</u> is the expectation that participation will help to produce the collective good. The other two types of motives are a function of the expected selective costs and benefits and the value of these costs and benefits. As distinguished in the reactions of significant others, these comprise the <u>social motive</u>. As they relate to nonsocial costs and benefits, they comprise the <u>reward motive</u>. The motives combine in an additive way, so that if one motive is weak or negative, it may be compensated for by another motive.

In Klandermans' view, two processes are used by organizations to initiate collective action and must mobilize the people to action. <u>Consensus mobilization</u> is the necessary first step and involves obtaining intellectual support for the organizational viewpoint. At this stage, there may be opposition from external or rival organizations. Consensus mobilization is necessary before <u>action mobilization</u> can occur. In this stage individuals are called upon to participate and attempts made to motivate people to participate through physical efforts or contributions.

Klandermans studied the effects of a mobilization
campaign among Dutch union workers, focusing on motives
and mobilization. In this sample he reports a large
contribution of collective motives for participation even
when the other motives are accounted for, which is in
opposition to Olson's argument that persons are not
motivated to participate in collective behavior by the
collective good but only by selective incentives. Group
solidarity was also an important determinant of
participation. Contrary to Olson's explanation of free
riders, the willingness to participate in collective
action appears to be strengthened by the belief that many
others will participate. The findings related to
mobilization emphasize the importance of adequate
diffusion of knowledge of the collective good. People
must know the effects of the collective good and believe
that the good will meet identified need. While action was
driven by collective motives, when consensus mobilization
failed, action mobilization lost its momentum and external
events made success unlikely, the collective motive to
participate vanished.

Participation is seen as a rational choice in the
situation as the person perceives it, and as a way to
obtain desired outcomes. In the eyes of the participant,
participation is a means of reaching valued goals.
Feelings of relative deprivation or frustration do not

necessarily evoke agreement with the goals of a movement

which pretends to remedy these feelings; goals have to be

perceived as instrumental to the elimination of these

feelings.

Oliver, Marwell, and Teixera (1985) examined

scenarios for collective action considering different

assumptions about heterogeneity of interests and resources

and the shape of the production function. In the Oliver

et al. model, heterogeneity is a key element. If an

interest group is heterogeneous, there may be some highly

interested or highly resourceful people available for a

critical mass even when the mean interest or resource

level is rather low. Study of collection action is misled

by treating a heterogenous interest group as if it were

homogeneous and examining only the aggregate group

interest in the collective Oliver et al. view the

problem of collective action as one of getting some

relatively small subset of a group interested in the

provision of a public good to make contributions of time,

money, or other resources toward the production of that

good. This subset is the critical mass needed to begin

any collective action. Members of the critical mass

diverge from the average in terms of interests or

resources; thus, heterogeneity of population is a key to

predicting collective action.

In contrast to Olson, who assumes isolated decision makers, these authors assume interdependence of decision making. Individuals take account of how much others have already contributed to a collective action before making their own decision about contributing to the action. Decisions are sequential, that is, individuals take turns, making their decisions one at a time.

Many real-life production functions involve the high start-up costs that characterize the accelerating curves. A critical mass of interested persons with resources is necessary to initiate collective action in these situations, start the action and bear the long start up costs. Efforts are required to organize, communicate what is being done, educate the people as to their interests, and foster mass action.

Feasibility is a central problem because collective action must start at the flattest part of the curve. Therefore, collective action rarely even begins. Because each contribution makes subsequent ones more profitable, individuals might reasonably conclude that "starting the ball rolling" with a good example would produce widespread enough participation to justify the investment, even though they could not predict the exact chain of events.

In Thomas' (1986) study of neighborhood councils in Cincinnati, he identifies five factors that limit a neighborhood organization's ability to influence local

government decision making processes: a closed decision
making process, limited geographic representation, lack of
formal accountability, imbalance of resources, and the
dominance of professional values. To the degree that
organizations can overcome these factors they can be
effective in achieving their demands on local government.

Population characteristics affect participation rates
in the neighborhood organizations studied. Blacks
participate at a lower level: 60% that of whites. When
home ownership status is considered, white renters
participate at the lowest rate (Thomas, 1986).

Thomas reports that black residents view
participation in neighborhood organizations as a means to
an intermediary in communicating to public agencies on
problems concerning public services. This does not mean
that blacks are heavier services users, but that they have
a greater need for an intermediary.

Thomas' results support the importance of "threats"
or "precipitating incidents" in organizing and maintaining
the groups. The right issue can catalyze neighborhood
involvement despite previous lack of organizational
resources. In addressing problems, confrontation was more
effective in preventing change, while cooperation was
usually more effective in promoting development.

As the organizations succeed in their efforts and fewer
problems arise to be solved, the active interest of the
group decreases (p.119).

A different approach to developing an understanding
of collective action is taken by Crenson (1987). He
maintains that collective action is commonplace rather
than rare and that it is rational when it occurs within a
framework of enduring social relationships (for example,
neighborhoods). Crenson characterizes the problem as one
of explaining how and why people initiate such
relationships in the first place.

Using an example of a woman who started a one person
street clean-up project in her neighborhood, Crenson
argues that the costs of abstaining from participating in
production of the collective good are higher than those of
participating. Key to the success of such efforts are an
activist with a strong preference for the good, sufficient
resources available to the individual who initiates
production of the good, and belief that one individual's
actions can influence the behavior of others. In a sense,
the activist functions as an entrepreneur who invests her
own resources to provide a collective good. By altering
the context within which other individuals make decisions,
the likelihood of continued production of the collective
good is increased. In addition, maintenance of the
collective good is enhanced by the social relationships

among those receiving the collective benefits. Social
pressures can create a situation where the costs of free
riding exceed those of participating in production of the
good.

The neighborhood residents most interested in
collective goods and who initiate collective action in
neighborhoods may have more resources including money,
spare time, and skills than other neighborhood residents.

Crenson maintains that decisions regarding
participation are not made independently, but are
interdependent, based on expectations about the behavior
of other members of the social group. Rationality and
self interest have not been discarded, but are being
measured by other than economic or material standards. In
this case, rationality dictates conforming to social norms
of the group.

Davis (1991) studied collective action in Cincinnati
that fought against urban renewal projects. He
characterizes his study as a study of "locality based
organizations", meaning that the people being organized
are residents of the same general area.

Major variables that determine the conversion of
latent interests to manifest interests and quasi groups to
interest group identified by Davis included the
interaction of groups within the community and shared
ideologies that consolidate groups with seemingly

different interests. Davis assumes the existence of a "quasi group", that is, people with similar latent interests, who through conversion are pushed into a "group".

In Davis' study the empirical conditions of organizations affect whether or not a group is formed. The social conditions of the neighborhood, including homogeneity of the population and the physical distribution of the population throughout the geographic area, affect formation of a group. When the physical and social distance between people is smaller it will be easier for them to form a group (Davis, 1991, p.273). Long time residence in an area and interaction with the same collection of people over a long period of time positively affects the recognition of common interests and produces a set of people that are far easier to organize than those who are transients passing through the area.

Political conditions can create a supportive environment for organizing. If many competing groups are within the neighborhood it will be difficult to establish a new organization. The current organization may exhaust the financial leadership, and volunteer resources needed for a new interest group.

Finally, there are four technical conditions of organization. Some sort of normative structure for the

group must exist, either formal or informal. An
organization must have material support sufficient to meet
the organization's goals and personnel, both in the sense
of membership and leadership. Founders and leaders are a
technical prerequisite for organization, development, and
maintenance of groups.   Davis suggests from his community
studies that leadership may be the most important
variable, but also the most theoretically elusive and
empirically unpredictable. Two organizations existed
within the same array of social, political, and technical
conditions which permitted, promoted, and sustained both
organizations. One group had politically conscious and
organizationally sophisticated leadership and functioned
well for nearly ten years, while the second group had a
lower level of leadership and has remained a poorly
organized group. Theories do not explain the emergence
of leadership in one group and not in the other. The
"charter" of the organization is the final technical
condition and reflects the manifest interests of the
organization, articulating and codifying the purposes,
its mission, and its goals which are its reason for being.

BUILDING A FRAMEWORK FOR ANALYSIS

When concepts from resource mobilization theory are
added to Olson's postulations a possible explanation of
collective action in low resource neighborhoods emerges.

Although different theorists use varying terminology, they use concepts that are complementary and in combination build an explanation. Factors emerge which are related to explanation of collective action in low resource neighborhoods. Henig's categories of extraneighborhood, neighborhood contextual and neighborhood situational are used to organize presentation of the factors.

Extraneighborhood

Events and institutions outside the neighborhood play an especially important role in collective action in neighborhoods with limited resources. Other organizations in the external environment can provide the resources needed for the collective action or may provide political support for the action. Resources include individuals with discretionary time and institutions with slack resources as well as money (Jenkins, 1982) .

The local political system impinges on the neighborhood. Local government with an open decision making process allows easier access by neighborhood organizations (Thomas, 1986), while the specific positions taken by political elites affect achievement of collective action goals (Jenkins, 1982). Routine shifts in the power structure create openings for access. Governments may enact legislation or regulations that create an environment supportive of the specific collective action, or collective action in general. The bureaucracy then

56

becomes important as officials may or may not implement the legislation or regulation or may act in a manner to impede rather than facilitate the collective action.

Neighborhood Context

Collective action takes place within the social context of other exchange relationships (Hardin, 1982) and for many low income persons that context is the neighborhood. The nature of the immediate community affects a group's ability to engage in collective action. When the physical and social distances between people are slight, interaction is enhanced (Davis, 1991). Interaction creates subgroups of the larger body of residents and eliminates some of the problems Olson (1965) identifies as interfering with collective action in large groups. The smaller groups present opportunities for social incentives and pressure.

Long time residence in the neighborhood allows interaction over time and development of an awareness of others' interests and concerns. Cultural homogeneity contributes to a shared world view as well as shared conditions and experiences and creates cohesive neighborhoods more likely to engage in collective action (Henig, 1982) .

Residents have common knowledge of the expected behavior and a preference for the behavior among the group members (Crenson, 1987; Hardin, 1982). Although the rules

57

may not be written down, residents have expectations about others' behaviors and sanctions are possible if members violate contracts. Sanctions may be explicit such as withholding valued goods, or implicit such as loss of trust in those who fail to conform.

Social norms of the community can provide the rationale for participation (Jenkins, 1983; Crenson, 1987) . Groups with a high level of interaction are more readily mobilized for collective action. Communities in which members interact for other purposes, such as religious or social, are more likely to conduct successful collective actions.

Interests and resources are distributed unevenly among the neighborhood residents, and must be combined for successful collective action. Individual neighborhood residents have different levels of interest in the collective good, with some persons having much higher levels than others (Crenson, 1987; Oliver, 1985). Highly interested persons can serve as catalysts to initiate collective action and as the glue that holds the group together until the collective good is achieved. At the same time, resources are distributed unevenly throughout the neighborhood, with some persons having more resources than others including money, discretionary time, and needed skills. The individual with the high level of interest may not be the one with a level of resources to

support the collective action. Therefore, the highly-
interested individual must phrase the issue in such a way
as to attract those persons in the neighborhood with the
resources. Especially when resource levels are low in the
community, some highly interested or highly resourceful
persons can provide a cadre of workers although the
general level of interest or resource is low. <u>Neighborhood</u>
<u>Situation</u>

Whether called leader, entrepreneur, or activist, one
or more individuals must take the responsibility for
initiating the collective action, taking the first steps
to pull a group together, and developing the resources
needed to obtain the collective good. Leaders must
generate solidarity and moral commitment (Jenkins, 1983)
and other incentives for participation. A threat or
precipitating incident will assist leadership in
mobilizing the neighborhood residents (Thomas, 1986). An
entrepreneurial model of leadership is most appropriate
for low resource neighborhoods. In this model, leaders
provide much of the capital (their own time and energy)
and develop other resources (Salisbury, 1969; Lachmann,
1978; Jenkins, 1983; Crenson, 1987). Leaders may come
from existing groups or be individuals with a higher level
of resources (money, skills, or knowledge) or a higher
level of interest in the collective good (Crenson, 1987).

A formal organization provides a process to pool resources and direct them toward the collective action, thus increasing the likelihood that groups of low income individuals will achieve their collective action goals (Jenkins, 1983). The organization, newly organized or already existing, serves as an institutional mechanism for coordinating collective efforts in pursuit of group goals and increases the likelihood of success in achieving collective goals (Rich, 1980b, Jenkins, 1983) .

Organizational structure and the tactics used by leaders affect collective action outcomes. A decentralized organizational structure increases grass roots participation and increases opportunities for interaction among the members although it may negatively affect organizational efficiency (Jenkins, 1983). The limited power of individual members of organizations in low resource neighborhoods results in organizations with relatively low power. To be effective, these organizations must engage in activities that emphasize their strengths. Protest activities or other noninstitutional means that involve large numbers of neighborhood residents are appropriate tactics (Piven & Cloward, 1977; Thomas, 1986, Gamson, 1990).

An existing organization's previous failures or successes affect its ability to attract participants in the immediate situation (Henig, 1982). The issue of how

organizations form when none exists is not well understood, although leadership is one resource identified as necessary for formation of a group for collective action and its continuation.

Organizations need a variety of resources, both tangible and intangible, to carry out activities. While a certain store of resources is necessary, the specific resource elements vary from group to group (Jenkins, 1983) . Deficits of resources in one area can be offset by surpluses in other dimensions, including entrepreneurial leadership that either provides the resources or obtains them from the external environment (Lachmann, 1978). Lack of monetary resources may be offset by resources in other areas, for example, indigenous leadership, an experienced organizer, institutional support, or community support. The level of resources must be perceived as adequate for the task to encourage participation (Rich, 1980b).

A critical mass of people is needed, yet it is not clear how many people are needed. A group must be large enough to accomplish the task, but no so large that individual contributions are not noticeable (Fleishman, 1980). An intermediate size group appears most likely to succeed because too small a group will be perceived as not having necessary resources, while too large a group loses its ability to apply social pressure and may experience free rider problems (Olson, 1965, p.50)

The assumption of complete information is inappropriate in many collective action situations. Potential participants may not have access to complete information nor pay attention to all the information they do have (Marsh, 1976). Instead, decision making situations are reconstructed in terms of the information available and processed. For successful collective action adequate diffusion of knowledge of the collective good is essential. Individuals must know the effects of the collective good and believe that the good will meet the identified need (Klandermans, 1984).

Knowledge of other individuals' beliefs and earlier actions creates expectations about their behavior in collective action situations. Decisions are not made in an isolated manner by individuals, but include expectations about the actions of others. After some individuals have made the decision to participate, and others learn of this decision, some of the others will follow (Oliver, Marwell, & Teixera, 1985; Crenson, 1987).

Although a wide variety of terms are used to describe the motivation for participation in collective action, two main groupings occur: economic and noneconomic motivation. Olson (19 65) focused on the economic rationale for participation in collective action, yet this rationale would predict nonparticipation in many collective action situations. Expanding rational

behavior to include other than economic factors increases the understanding of the motivation for participation in a wider variety of collective actions. Multiple motives are in operation at the same time and combine in an additive way, so that if one motive is weak or negative, it may be compensated for by another motive (Klandermans, 1984). Externalities or the cost of participation in the collective action must also be considered when discussing motivation. Costs of participation include opportunity costs as well as financial costs. On the other hand, nonparticipation may have social costs (Crenson, 1987).

Individual economic interests play an insignificant role in explaining motivation of residents of low resource neighborhoods. Purposive incentives derived from the stated ends of the action are important in these neighborhoods where feelings of deprivation occur among the residents. Individuals in these neighborhoods participate because the collective good is important to them, cannot be obtained without the collective action, and the good is perceived as instrumental to removing feelings of deprivation. They expect their participation to help produce the good (Klandermans, 1984).

Members of groups in low resource neighborhoods may participate because of moral motivations or a sense of fairness (Moe, 1980). They have a sense of public responsibility and concern for others' welfare

(Fleishman, 1980; Henig, 1982; Jenkins, 1983). Loyalty and commitment to the neighborhood motivates residents if collective good is perceived as improving the neighborhood (Gamson, 1990).

Solidary incentives, independent of the ends of the association, require ongoing relationships among individuals and are related to reactions of significant others (Clark & Wilson, 1961). Solidary incentives are important in communities where resources are low, access to status is limited, and interaction occurs among residents. Social pressure - ostracism or loss of status can be used to create a situation where the costs of free riding exceed those of participating in production of the good (Jenkins, 1983). Solving the Puzzle

By integrating elements of Olson's collective action theory and resource mobilization theory, several factors have been identified from the work of other scholars as part of the explanation of collective action in low resource neighborhoods. They include the resources and organizations in the external environment; existing organizations and opportunities for interaction in the neighborhood environment; and, within the situation, the valuation of the good by potential participants, leadership and organization, resources, and motivation.

The question is then, what is the mix of these
factors related to collective action that contributed to
the formation and operation of neighborhood health
centers? Three case studies of neighborhood health
centers will be presented and then analyzed to determine
whether these factors explain the collective action or if
other factors must be considered.

1. The assumptions of Olson's model are similar to those of the economic rationality model:

    1. The individual is rational.
    2. The individual has perfect information.
    3. The individual is motivated entirely by economic gain.
    4. Decisions to participate are made independently without consideration of the effects of one's decision on others.

2. A cadre is a handful of highly interested, individuals who define the issue and mobilize resources.

3. Salisbury prefers the use of "expressive" rather than purposive to describe organizations that provide a forum for public expression of values of the members (p.16).

4. Rich uses Olson's description of social sanctions and social rewards as "selective incentives" (see Olson, 1965, pp. 60-61).

5. Rich builds on Olson's (1965, pp. 33-34) description of individuals who will be leaders. They are individuals who: 1) place a high value on availability of the potential collective good; 2) believe that the good can be secured through collective effort at a relatively low cost; and, 3) can monitor each member's behavior with respect to that good.

CHAPTER THREE

COLLECTIVE ACTION ON THE SOUTHEAST SIDE

67

CHAPTER THREE COLLECTIVE

ACTION ON THE SOUTHEAST SIDE

The SouthEast Health Center (SEHC) opened on September 15, 1968, with a ribbon cutting ceremony presided over by Richard Lugar, Mayor of Indianapolis at that time. This was the culmination of two years of discussion and 6 months of intense activity by neighborhood residents to obtain health services in the community, health services that were financially accessible to all residents. Active participants in the process included persons from the neighborhood association, various neighborhood churches, social service agency professionals, and local ministers. The development of this health center is a success story that may provide insights into how and why collective action is a viable option in urban neighborhoods.

NEIGHBORHOOD CONTEXT

The SouthEast neighborhood is just to the south of the center of Indianapolis. It is among the older parts of the city, having been well developed and settled by 1870. Many of the problems that occur in this area are related to its inner city nature and the age of the structures in the area.

The boundaries of the fountain square neighborhood
enclose a somewhat smaller area than the SEHC catchment area
boundaries, but probably represent a "community of
solution" for problems in the neighborhood (see Figure
3.1).   This is the definition accepted by the Fountain
Square Merchant's Association and seems to be the common
definition among the people. However, the boundaries do
not limit participation on the board or receiving services
in the health center. When neighborhood people were asked
about neighborhood boundaries, they tended to describe a
neighborhood with their own homes at the center. However,
they were in general agreement with the larger
neighborhood definition presented above. Organizational
Activities

The area comprises a number of different small
neighborhoods. In the Sixties many factions existed
within the area, sometimes reflected in formal
organizations and sometimes not. A general sense of
divisiveness had contributed to a history of not being
able to get things done. The sense of community changed
after a successful battle related to an interstate highway
that cuts through the area.

Interstate-65 (I65) cuts through the neighborhood and
provided a focus for neighborhood collective activity. Ray
Sells, a Methodist minister who had just become director
of Fletcher Place Community Center, was one of

69
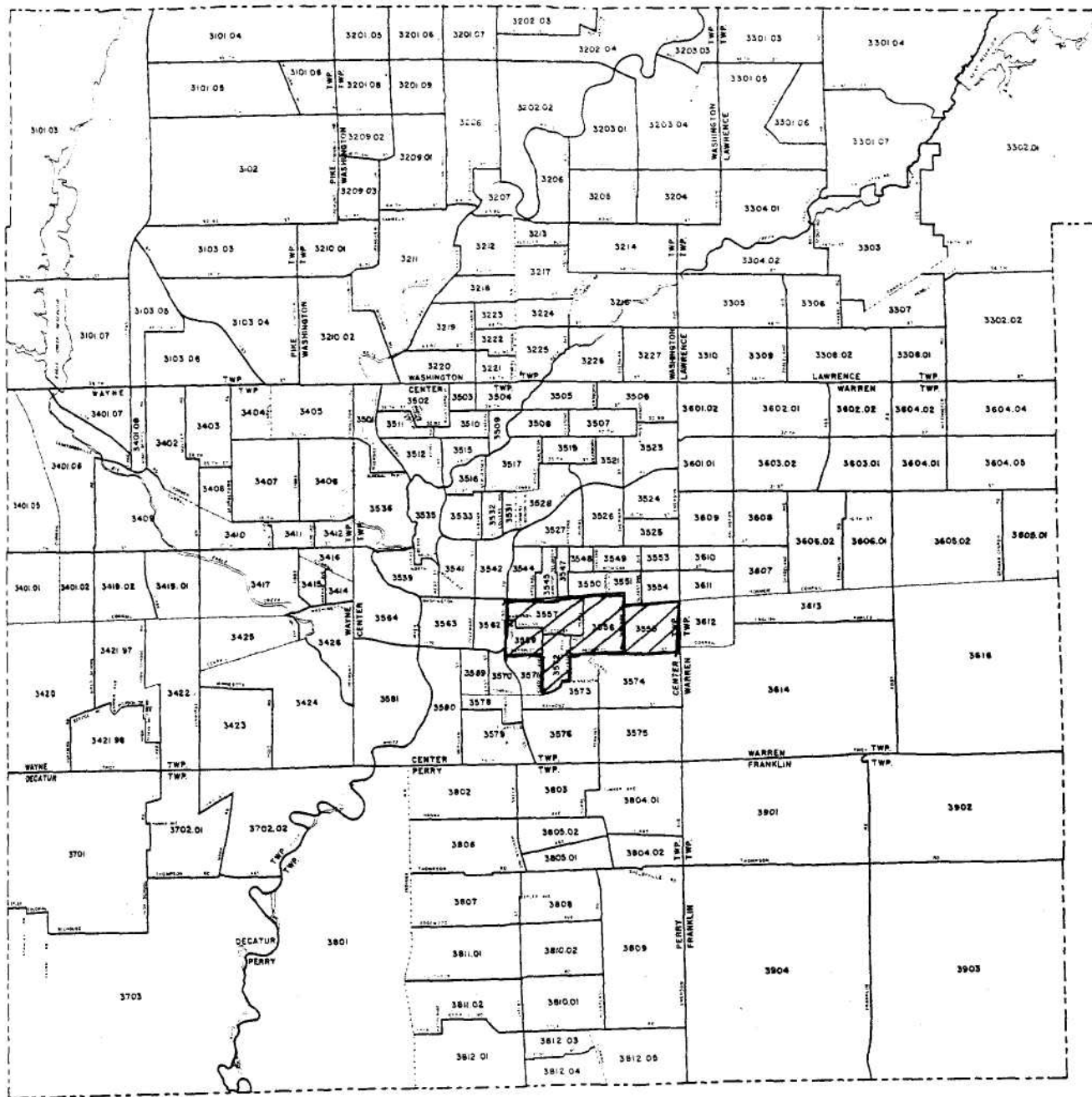
1990 CENSUS TRACTS

Figure 3.1   Southeastside Neighborhood
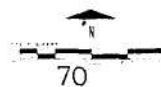
the leaders of this fight. A neighborhood organization, a coalition of the existing factions, was developed to work on this issue. The group was able to obtain replacement cost for houses that were removed and to prevent the elevation of the highway. Sells' role in this successful battle built neighborhood trust and set the stage for the later collective activities that occurred. The neighborhood was in the process of becoming one that did not ask for things to be done <u>for</u> it, but one that was willing, even eager, to take responsibility for its own needs.

The SouthEast area has been and continues to be a primarily low income white neighborhood with a substantial proportion of Appalachians. The area is affected by two types of transiency among the population. The health center chaplain suggests that earlier transients were moving north out of Appalachia and that the SouthEast area was the first place they stopped in the city, partly because the area is predominantly white. The migration from Appalachia continued through the sixties and may have diminished, if not ended, due to the decline of manufacturing employment in the Indianapolis area.

Other transients in the area simply moved from house to house, or engaged in "musical houses". A resident of the area just north of the center describes her neighbors as highly transient, with people moving in and out of

houses every two or three months. The amount of renter
occupied housing in her immediate neighborhood has
increased in the past few years. This suggests that the
old pattern of a highly mobile population still exists in
some parts of the neighborhood.

New residents are moving into the neighborhood, some
because of gentrification of part of the area and others
because of the economic decline of the neighborhood. Among
this latter group are the new family units, moving to this
area because housing is less expensive and they can
purchase a "starter home". Neighborhoods such as this one
make the American dream of home ownership a reality for
families that would not otherwise be able to buy a house.
However, house payments may strain their income to such a
point that other needs are not met. Stability of the
Community

Physical changes have occurred in the neighborhood in
the last twenty years, starting with the development of
I65, just before the activities related to the health
center were started. In addition, numerous houses have
been demolished because of their ramshackle condition.
Other physical changes have occurred because of the
continued intrusion into the area of the Eli Lilly
Corporation which has blocked streets and most recently
purchased the land where the farmer's market for the city
has been located for many years.

Residents' perceptions of changes in the population are mixed. One reported improvement in the economic conditions in the neighborhood while another reported declining conditions. This may reflect the immediate neighborhood around their homes. It is clear from the rehabilitation of some houses that at least some of the new residents have higher incomes than the area population in general. People

The total population of the area, although less than 30 years ago, increased by about 1,000 persons in the last ten years. During this time, the black population has varied, with a similar percentage of black residents in 1990 compared to that of thirty years ago (see Table 3.1).

Table 3.1
Population of the SouthEastside Area

	1960	1970	1980	1990
Total	19,003	16,822	16,003	17,040
Percent Black	4.4	5.5	5.0	4.3

Source: U.S. Bureau of the Census.

The 1980 census data support the perception of the community as one of lower socioeconomic status. The range for median family income in the area in 1980 was from $9,333 to $13,289 compared to the Marion County median

income of $17,400.[1] The discrepancy between the
neighborhood and the county has increased over the last
twenty years. Twenty-six percent of the residents were
living in households with incomes below the poverty level,
in contrast to 11 percent of the county population.
Educational achievement in the neighborhood is low with
only 45 percent of the population having completed high
school, which is comparable to the Center Township level,
but lower than the county (68%) . Institutional Resources

Churches of various denominations are among the
major institutions in the neighborhood. The Fletcher
Place Methodist Church was built in 187 2 in what was then
an affluent community. Although the United Methodists
were leaders in the development of the health center,
other denominations were active participants in the
process. Two other churches in particular, the United
Church of Christ and the St. Patrick's Catholic Church,
have been a source of support for the health center,
providing board members with expertise in a variety of
areas.

A district office of the Marion County Department of
Public Health is located in the neighborhood. Public
health nurses from this office have been members of the
board and provided leadership. Other organizations in the
neighborhood include a Girls' Club, Boys' Club, and

Salvation Army). Curiously, none of their staff have been involved in the health center. For unknown reasons, they seem not to have been approached and invited to participate, nor have these organizations initiated contact.

A neighborhood shopping area around the fountain formerly met all the shopping needs of the community and continues to be a focus of activity. Many of the businesses are small and locally owned. Reminders of a more prosperous era are the Murphy's store and a branch of a major bank.

The Fountain Square neighborhood residents are quite proud of their area and show great attachment to it. They attend church in the area and support the local businesses. These characteristics are conducive to working collectively towards obtaining services they perceive are needed in the community.

Nevertheless, a general feeling exists among residents of the south side of the city that they have received the short end of the stick when compared to services provided to other areas in the city. In some cases, their requests for services have followed knowledge of what is occurring in other areas and trying to get their fair share.

DEVELOPMENT OF THE HEALTH CENTER

In the middle sixties, there were many poor people in the area. Chronic diseases were prevalent among the population at a high rate, as well as a high incidence of acute conditions that required medical attention. Requests for assistance sought through agencies in the broader community were either rejected or met in ways that were deemed unacceptable and lacking in human concern by neighborhood residents and agency persons. Although Indianapolis is a city with numerous large hospitals and the Indiana University School of Medicine (and associated Medical Center), this does not mean health care was accessible, economically or geographically, for low income families. During this time period the Medical School did not offer community experiences to their students and offered no services in this community. Although dental care was available at the Indiana University School of Dentistry at a very cheap price, neighborhood residents felt it was second class care as "people work on you to learn".

The county provided well child care at Fletcher Place Community Center through the Marion County Health Department. However, this service was for a very restricted population and was also restricted in the

nature of the services. Health care was available for the poor at the county hospital, but it was difficult as well as time consuming to use the clinic services at the hospital. Utilization of the hospital clinic services entailed a bus ride with transfers, which took more than an hour. Upon arrival at the hospital, patients spent the entire day working their way through the system. As one neighborhood resident put it, "they took your clothes at eight and gave them back to you at five". This woman considered herself lucky as she had the money (25 cents) to buy a soft drink during the day. For other families, the long day created problems. Women with no money spent the day there with children who would be hungry and crying. Since they rarely had the money to pay for a baby-sitter and the process for obtaining health care was perceived as demeaning, many families simply stayed out of the health care system. For many neighborhood residents, the perception of the county hospital as providing a de-humanized version of medical care eliminated the hospital as a viable alternative source of care.

Private physicians who had practiced in the neighborhood were leaving to go to more lucrative areas. One physician remained in the area, but he was old and did not take new patients. During 1964 and 1965 attempts were made to recruit additional physicians to the area. It quickly became clear that no physician was interested in

coming to a neighborhood suffering from an economic decline.

Through negotiations with the health department in 1966, arrangements were made to use space in Fletcher Place Community Center for provision of health care by a volunteer physician. It was quickly apparent that the services provided through volunteers were inadequate in quantity, regularity, and comprehensiveness. <u>Getting Started</u>

The lack of accessible health services became evident to most neighborhood residents and was frequently the topic of informal discussion. There seems to have been no disagreement with this as a major problem for the neighborhood.

In the beginning development of the health center leadership came from two general sources: the professionals working in the community and the grassroots people. Local institutions provided an essential resource to the collective efforts - persons trained in community organizing. Fletcher Place, both the Methodist Church and the Community Center, was a source of leadership. Ray Sells (Minister) and Jim Kohls (Assistant Minister) functioned as entrepreneurs, starting the health center organization and meeting their organizations' needs also. These men brought with them a radical perspective and an understanding of organizing and Alinsky principles.

Sells, a Methodist minister, was assigned to the
Fletcher Place Methodist Church in 1965. He had no
knowledge of the area or what was awaiting him. However,
the great needs in the neighborhood were immediately
apparent. He provided continuing leadership for
collective activities and was responsible for bringing Jim
Kohls, an Alinsky trained Methodist minister, to help with
organizing the neighborhood.

Neighborhood professionals became involved for other
reasons. Certainly they were interested in obtaining the
collective good, health care services, but they also
wanted to develop a more cohesive community. The local
Catholic church was a source of leadership. A young
priest fresh out of seminary was seeking a way to make the
church relevant in the community and became active in the
organizing activities. Although he was sometimes reminded
that he was not poor like the residents, he became a
leader because of his ability to articulate the issues and
his willingness to work.

Although the grassroots people were essential to the
development of the health center, substantial organizing
efforts on the part of the staff from Fletcher Place
Community Center were required. These efforts focused
first on developing a community group with broad based
membership, and then moved on to addressing issues related
to health and housing.

The grassroots people involved in the development of the health center were primarily those who had been active in other neighborhood organizations (both old and new) and church activities. Even though strenuous efforts were made to involve many people in the process, leadership tended to be provided by a small cadre. The organized effort to obtain services began within the Fletcher Place Neighborhood Association (FPNA), the organization developed by the staff at Fletcher Place. Hannah Briner, a long time neighborhood resident, was president at the time and played an active role in the pursuit of health care services. The FPNA served as the catalyst for activities until a new organization was formed.

Other grassroots leadership was provided by Lester Neal, a local Republican politician. He was a major participant in the development and operation of the health center. Neal was involved in the activities from an early stage and served as the link to local government. In addition, his business expertise helped in carrying out activities of the new organization. In retrospect, many board members have questioned Neal's motives, suggesting that his motives for participation were for financial and political gain. As was later learned, the organization may have been overly reliant on Neal, ceding large amounts of responsibility to him with little oversight.

Leadership continues to come primarily from old time Board members and neighborhood residents who are active in other neighborhood organizations or local churches . One past president (A.Good) described the role of leadership as "to teach". She provided guidance to committees in organizing and identifying their responsibilities and prompted the Board membership to prepare for meetings by preparing an agenda with greater detail than is sometimes presented. Her view of leadership is that it requires imagination. Recruitment of New Members

Recruitment of members was not a problem in the early days of the Board. Participation was easily obtained through telephone calls and personal visits. Agreement among neighborhood residents that the need for the health center was so great, that little effort was required to get people to come to meetings and become active members. People felt they were doing something valuable and that their efforts made a difference.

Anyone who signed an attendance sheet at any meeting was considered to be a member of the Board. Although this turned out to be confusing in later years, it had the effect of vesting ownership of the project in a large number of people. Sells described it as a community effort, with little interest in delineating who was or who was not an official member. In his words, " It was kind

of like a party, if you showed up, you were in on it." As
the organization became more formal, greater attention was
paid to who the official members were, but in the early
days "there was just a matter of gathering of folks who
were committed and concerned about what we were doing."

Membership was not limited to neighborhood residents.
A small number of members came from other areas of the
city. Reasons for these members' interest in the health
center are not always clear from reviewing documents, but
in some cases, participation reflected an ideological
commitment to local community control. Health Center
board members from that time period hold differing
perceptions of the size of the initial organization,
ranging from 75 to 150 people. Review of minutes and
attendance sheets from that time suggest that about 60
people were regularly involved. However, it seems clear
that participants were impressed by the number of persons
involved. This was a positive factor in the operation of
the organization, contributing to its ability to obtain
resources from within the neighborhood and outside.

Initial board members were not necessarily persons
who would be users of the health center (see Table 3.2).
Original members included church leaders and ministers and
their wives, local politicos, and Methodist Hospital staff
as well as neighborhood residents. When recalling the
early days, board members have suggested that the

community people who were active in getting the health center going were not the lumpenproletariat of that area. However, in reviewing the membership lists of the early years, several members list themselves as not having telephones which suggests they were indigenous neighborhood people and likely users of the services.

The motivation of the original group of grassroots people was quite simply that they wanted medical services in their neighborhood. With one exception (addressed later) , there seems to have been no economic explanation for participation. For the professionals at Fletcher Place Community Center, they were trying to respond to a community need, but also had a much broader vision of trying to organize the whole community. The health care issue was used in hopes of generating a greater sense of cohesiveness in the community. These people also wanted to have an impact on the health care delivery system in the city, making it more responsive to the people.

Table 3.2
Example of Membership Characteristics

Type	Men	Women
Church Official	9	3
Community	15	22
Outside of Community	12	4
Methodist Hospital	2	0

One view expressed by one early board member is that
there are two classes of people who become board members.
In the first class are those who want to be important and
believe board membership will enhance their importance. In
the other class are those persons who recognize the
importance of the goals of the organization and know that
if they are to be achieved, their own participation is
required. In essence, they value the good so greatly they
are willing to give their time to efforts to obtain it. It
is this latter group who are the real "guts" of an
organization. The SouthEast neighborhood was fortunate to
have many residents who understood the need for medical
services and committed themselves to obtaining them for
the community, not just themselves.

One original board member and her husband lived
outside the immediate neighborhood and attended a
Methodist church in that neighborhood. This woman's
husband was perceived as a person with the ability to
organize activities, a skill needed in the Fletcher Place
group. The couple were asked by the minister of their
church to change their membership to the Fletcher Place
United Methodist Church and help them with efforts to
organize activities.

Some board members had been poor at some time in
their life and expressed empathy for other persons in that

condition.   One woman explained that she had gone through the depression, and although never "on relief", had bought old clothing for use in making clothing for her children. It was the remembrance of those times that prompted her to become involved in the activities related to the health center.

Local institutions supported the efforts in a variety of ways. Briner, who became a leader in the group, was employed as an aide for a local social service agency. Her supervisor allowed her to work on health center activities during working hours. <u>Institutional Contributions</u>

Organization of the new group was facilitated by staff at Fletcher Place Community Center, in particular, Ray Sells who was minister at Fletcher Place Methodist Church and director at Fletcher Place Community Center. Many of the neighborhood people were involved in activities at the center and joined in the activities related to obtaining health services. This new group was called the Committee of Concerned People of the SouthEast Inner City. This people's committee secured the support of many other churches and organizations in the area.

When discussions about obtaining needed services began, there was a holistic conception of health, with medical services being only a portion of the needed services. However, the direct health services piece was

believed to be the easiest part to carry off and win,
providing a success on which to build. The need for
health services in the neighborhood was an issue on which
the leaders thought everyone agreed. And indeed this was
true. When board members were asked about disagreements
about the selection of a health center as the means to
meet their health care needs, no one was able to identify
any dissension on the issue. It was clear to them that
private practitioners did not perceive the area capable of
generating sufficient income to merit a move to the area.

An important factor supporting the development of the
health center in the SouthEast area is the presence of the
United Methodist Church in several forms. There are three
Methodist churches in the area in addition to Fletcher
Methodist Church and its associated community center. The
Fletcher Place area has been designated as a mission area
by the Methodist Conference since the sixties. This
designation means that the church hierarchy provides
financial support for the local church when the
congregation is unable to provide adequate resources. In
the sixties, the church supported staff at the Fletcher
Place Methodist Church and at the Fletcher Place Community
Center. The staff were young, aggressive, and
characterized as "fighters for social justice". The
community center was involved in a number of activities
perceived by staff as contributing to the well-being of

the community and helping community members to develop
their own skills at identifying needs and obtaining
solutions.

Methodist Hospital played a central role in the
development of the health center, providing the needed
institutional base. Participants in the initial
development of the health center believe that it would
never have been started without the commitment of
Methodist Hospital. In the search for funds and medical
services for a health center, the neighborhood group
turned to Methodist Hospital. Members of the group then
met with an administrator (Jack Hahn) at Methodist
Hospital, seeking the hospital's help in obtaining medical
staff and guidance in operating a health center. They had
assumed it would be relatively easy to get hospital
cooperation. Instead, they were told by a hospital
administrator that if people needed care they could go to
the county hospital or come to the clinics at Methodist
Hospital and be seen. They were sent away with the charge
to gather material that would convince the administrator
of the need in the community.

Another view (Sells) of this initial rejection of the
request for health care services is that Methodist
Hospital was reluctant to allow the control of the health
center to remain in the hands of the neighborhood
organization. From the very start the discussions had

included the notion of the neighborhood corporation controlling the health center and the hospital had resisted this. Hospital administrators may have thought they could take control of the center, little by little, once it was opened. However, when a disagreement occurred, Sells threatened to "put 150 people in front of the hospital to protest" and the neighborhood group remained in control.

To meet the administrator's demands, the committee members conducted a survey in the neighborhood and collected information to document the need. Data in hand, they met again with Hahn, who was convinced that services in the area were needed. However, at that time Methodist Hospital was still under the jurisdiction of the Methodist church and hospital administrators on their own, could not make the decision to support the health center. Hahn recommended that the next move be to attend the South Indiana Conference of the United Methodist Church and request support of the project.

A group of about five persons attended the Conference held in Bloomington and staged a peaceful demonstration. Hannah Briner, a neighborhood woman was selected to speak because, as she described it, "One of the reasons Ray [Sells] had me speak was that I was an indigent and was not used to public speaking and he knew I would just be myself and get up there and talk." The group appearance

created quite a stir among this usually staid group, and convinced the group of their need. Methodist Hospital was directed to assist the group and the Conference promised some financial assistance.

Consistent with their religious philosophy, the hospital has a mission statement that speaks of the hospital as being a charitable institution, dispensing "relief and charity to the poor and destitute".   In combination with the philosophy, incumbents in positions of authority genuinely believed that they were fulfilling the mission of the hospital in helping the health centers.

Organization Structure

In designing the Health Center Board, it was decided by Sells and others to involve as many people as possible in active roles. Positions were established for sixteen officers, with "assistants to the assistants". The idea was to help the people to feel significant in the project. Both Kohls and Sells preferred to work, behind the scenes, staying out of the limelight, and were supportive of decision making and control by the neighborhood people.

Multiple committees were established to address every aspect of developing the center and these met frequently (see Table 3.3). The logic was described as "the more people out there are talking, the more people are interested". After incorporation there were 13 officers, 5 standing committees (Executive, Finances, Audit,

Membership, and Operations). As the organization
continued other committees were added, including Fund
Raising, Nominating, Program, and Blood.

In developing the health center many meetings were
held, sometimes more often than once a week. Much
discussion about the issue occurred outside of formal
meetings, with neighborhood residents talking about the
health center as they met each other in their usual
activities throughout the neighborhood. The presence and
high use of the neighborhood shopping area facilitated
this process.

Table 3.3

Original Committees

Location Committee	Building Committee
Fee Committee	Area Committee
Medicine and Supply Committee	Martindale Committee
Personnel Committee	Nominating Committee
Budget Committee	Fund Raising Committee
Political Committee	Survey Committee

Committees in their work identified questions that
were beyond local expertise. Linkages to outside
resources were provided through poverty programs and
social service agencies in the neighborhood. One example
of this is the recruitment through a social worker of the

Head Start Program (Pat Selmanoff) of her husband, a
sociologist, to conduct a needed survey of the
neighborhood. This has had long term effects as he has
remained a member of the health center board since that
time. In addition to providing valuable input into
decision making, he has served as a link to the academic
world that has resulted in other surveys being conducted
for the neighborhood and students in professional schools
(e.g. , Social Work, Nursing) working with the organization.

Determining the boundaries of the area to be served
by the health center was the role of the Area Committee.
Board members were welcomed from any area of the city.
However, it was intended that the health services were to
be limited to residents of the Fountain Square
Neighborhood, which is about four census tracts.[2]

The Building Committee, chaired by Lester Neal,
investigated numerous potential sites for the health
center. Eventually the Virginia Avenue Bank Building was
selected as the most appropriate for the center's needs.
Rent was established at $125 a month, with the first month
free if the group cleaned and painted the building. Group
Activities

One Board leader distinguished among the various
types of potential activities for members saying, "Things
that were kind of hands on, working on buildings and

doing things, you had a better chance, than things that were kind of conceptual..."

The professional members worked hard at trying to make the neighborhood people really make decisions and feel the control and responsibility. This is not to say that as staff they didn't have ideas and didn't try to influence decisions. Staff tried to allow the grassroots folks to make decisions rather than having the staff make decisions and take them in for the groups to ratify. Conceptual issues were difficult for the neighborhood folks unused to dealing with abstractions and issues beyond their everyday life. Outcomes from more abstract issues are not immediately apparent and progress more difficult to see.

The big decisions were sometimes easier than the small ones. Big decisions, such as changes in services to be provided, tended to be well developed when presented to the board by the administrative staff. Decisions of this nature usually involved commitments from the hospital and the Board decisions had to involve a certain reliance on the expertise of the hospital to guide the decisions. Board members did not express a feeling of manipulation in these situations, but just that this was the way it had to be.

Many of the neighborhood residents lived marginal economic lives and were faced constantly with difficult

situations. Handling the events of everyday life, such as

getting to work when you don't have a car, could require

the full attention of neighborhood folk and completely

divert them from the collective activities. They were not

accustomed to winning disagreements with persons they

perceived to be powerful, such as hospital administrators

or city officials, and would become discouraged. At other

times, "if something didn't happen, or somebody would say

this" they would get discouraged or angry. At times their

anger was useful, because in meetings with officials, they

would pour out their pent up feelings and be very

convincing in their demands.

   The Board members were most comfortable with tasks

which required physical effort and for which they could

see their progress almost immediately. Almost every

member cited positively, even fondly, the work done to

prepare the building for use as a health center. The wide

participation by neighborhood residents of every religious

background seemed to confirm the truly ecumenical nature

of the efforts to obtain a health center. The renovation

of the building was a totally volunteer effort. The

responsibility for the work was assigned to FPNA and was

coordinated by one member of the organization. However,

the requisite labor came from throughout the community.

Everyone pitched in to clean and paint both the inside and

outside of the building. One group worked inside laying

tile and building partitions.   The women who cleaned the old vault joked about hoping to find gold there.   These efforts confirmed the grassroots nature of the project. The community people were there, saying "this is our clinic" and they were doing the work to get it ready.

Working toward the opening of the health center involved many activities that required both intellectual and physical work by group members. After the health center was opened, interest fell and it was more difficult to obtain participation in the organization. Attendance at meetings dropped to only a few members.

As in most organizations decision making was guided by Roberts Rules of Order. Decisions were to be made by a simple majority of those attending the meetings. Documents from this time are incomplete, but it appears that the process was followed and frequently involved much debate and discussion.

It is surprising that there were not regular interactions between Board members and other persons involved in neighborhood health center activity. Even today, neighborhood people are unaware that neighborhood health centers were being built all around the country at the same time as they were developing SEHC. They believe that their efforts were unique at the time and preceded others' efforts.

<u>Resources</u>

Funding is the primary resource needed to operate a health center. Although the process followed is not always clear and is sometimes even confusing to the Board members, the SouthEast Health Center has had access to a wide variety of funds. In the beginning stages of the health center, funds were obtained from, in addition to the United Methodist Church and Methodist Hospital, the Indianapolis Foundation, Lilly Endowment, Junior League, Regional Medical Programs, and the city. The neighborhood group was expected to raise $10,000 towards the expenses of the health center.

When the health center started, money was needed to renovate the building, pay the rent ($125 per month), and purchase supplies and equipment. The neighborhood group appears not to have raised the expected amount, but managed to keep enough money in their account to cover building and supply expenses as they occurred. Methodist Hospital committed to paying for the personnel for the first quarter, which was estimated at $8,000 per quarter. Other funds were to come from the United Methodist Church's Reconciliation Fund. Neighborhood residents tend to credit the hospital with the full funding at this time, but it was a joint effort between church and hospital.

Application for funding was made to the Metropolitan Health Council, which had money available. The goal was for the health center to be self supporting to the degree possible.

A fund raising committee was appointed to raise the money needed to operate the center. At least $6,000 was needed in the treasury in order to be able to pay for rent and purchase needed supplies for the first year. General memberships were sold for $1.00, while businesses were asked to pay $100 for a membership. One of the innovative ways funds were raised was through contributions of neighborhood residents to the Blood Bank. Records for the first year of operation of the center show that $815, representing ten percent of center income, was generated in this manner.

The clinic was to be open two afternoons and one evening a week. Methodist Hospital assigned a family practice resident who also functioned as medical director of the health center. Other staff were to be paid rather than volunteer. Community members felt that, because of the confidential nature of medical care, it was not appropriate to use neighborhood volunteer workers. Interestingly, Junior League volunteers from outside the neighborhood were accepted as appropriate in the health center.

When the health center opened no agreement had been reached on how much to charge. It had been discussed that a one dollar fee be charged or that there be a sliding fee scale. There was concern that _all_ patients be accepted regardless of their ability to pay. Since there was no agreement, the center operated for several weeks without any charge.

By May, 1969, the number of clients had increased greatly and the center was generating income of $3 0 to $7 5 per week. The Virginia Avenue Bank Building had been outgrown and sources of funding for a new building were being pursued. At about this time, the health center was approached by Model cities staff and asked to consider moving the center so as to be within the Model Cities area. This request was rejected, with the comment that if the center moved anywhere it would move more into the center of its own community, not farther away.

Lester Neal, through his business contacts, was instrumental in obtaining the building at 901 Shelby which continues to house the health center. The building was purchased for $1.00 from the Indiana Mortgage Company and a waiver obtained for the $6,000 in back taxes owed the county. A proposal was written by the SEHC board with the assistance of the Fletcher Place Community Center staff and submitted to the Lilly Endowment for funds to renovate

the building. Funding was subsequently received in the amount of $150,000.

Threatened loss of funding for services has created numerous crises throughout the history of the health center. The incidence of these crises follows the changes in national government from liberal to conservative and back again. One crisis occurred in 1971 when the U.S. Department of Health, Education, and Welfare (DHEW) budget was cut. DHEW approved a grant proposal for the center, but then said there were no funds. At the same time, the Regional Medical Program (RMP), a state program, went on record in support of the health centers but supplied no funds . The health centers then turned to Flanner House and the Health and Hospital Corporation with requests for additional funds, but neither was able to increase their support. It appears that at times like this, Methodist Hospital provided the funds to operate the center until other funding was forthcoming with some payback of funds as they became available.

Although membership and attendance decreased during times when the center is operating smoothly, funding crises brought renewed interest in the Board. When these crises occur and a threat to continued services is perceived, a larger number of persons attend Board meetings. It appears that neighborhood folk are quite comfortable allowing the staff to continue with routine

operation of the health center, but will come forward when they perceive they are needed.

The health center is no longer a storefront operation, open on a part-time basis. It has turned into a more sophisticated system and produces a high quality of care. In some ways the Board has been protected from the harsh realities of the financial realm. Throughout the early years, Methodist Hospital assumed responsibility for paying personnel, including highly paid physicians. In March, 1971, these cost had reached $260,000. To underwrite these costs, the hospital in turn, obtained grants from various sources, including the Indiana Regional Medical Program (funded by DHEW) and the Metropolitan Health Council. Methodist Hospital staff took major responsibility for seeking funds, with occasional assistance with local fund sources from Board members, especially Lester Neal.

The Board, on the other hand, owns the building and has the responsibility for its management, both physical and financial. Responsibility for full financing of the health center did not come until precipitated by changes in the way federal grants were made and HealthNet was developed (see Appendix 6).

In 1973, the SEHC operated on a budget of approximately $300,000, of which $55,000 was expenses generated by Methodist in the operation of the center.

Funds were received from the IRMP(state), CAP(federal), CSP (city) and Lilly. Patient fees had generated about $30,000 and it was decided to use these funds to help pay the expenses incurred by Methodist. In 1974, SEHC received $100,00 from CSP and $31,900 from the Metropolitan Health Council.

The primary source of funding for the health center in recent years has been the federal government. Grant approval, consultation, and oversight are provided through the DHHS Region V office in Chicago. Although funds from this source are essential to the operation of the health center, Board members have little confidence in the ability of the DHHS, especially the Regional Office, to do what is best for the health center. Changes in national philosophies, high turnover among Regional staff, and power struggles within that staff have resulted in inconsistent and seemingly illogical decisions. This is an area where Board members feel frustrated in their lack of control of their own center.

As federal funds have become the major source of operational funds for the center, new concerns have risen. Concern was expressed by one staff member that the reliance on federal money will destroy the grassroots nature of the center. His perception was that part of what made the Board a strong grassroots organization were the activities centered around fund raising. Because the

federal guidelines <u>require</u> a community group, spontaneity
is lost.

<center>OPERATION OF THE HEALTH CENTER</center>

SouthEast Health Center Board members often say,
"We're the best in the city," One of the recurring themes
in conversations with Board members is the pride they have
in their neighborhood and the health center Board. Members
believe the Board, the health center staff, their building
and its location, and their neighborhood are the tops:
"everything it takes to make a good health center work".
They make it clear that they don't want to put anyone
else's neighborhood down, but they have a strong belief in
the value of what they do and how they do it. <u>Demand for</u>
<u>Health Care</u>

The neighborhood and the Board members have changed
since the health center was developed; however, the demand
for services has continued and increased, not decreased. A
larger portion of the Board members use the health center
as their primary source of medical care. This is a
function of several factors. One is that the Board
members have aged, resulting in a decreased income in some
cases, and less ability to go out of the geographic area
for medical care. Another factor is their changed
perception of the health center. When the center was
started it was viewed as being a clinic for the poor.

<center>101</center>

Today, the high quality of care provided serves as an incentive for all types of persons to use the center. Consensus in the neighborhood is that the health center represents an essential service for the area.

When Methodist Hospital began the relationship with the health center it was, in some ways, the beginning of a "honeymoon" that continues twenty years later. Early battles over control appear to have been forgotten by board members, possibly because there are many new board members. Methodist Hospital, on the other hand, now has confidence that neighborhood control of the health center in no way threatens the control of the physician over medical matters. Although medical and administrative services are provided by Methodist Hospital, the neighborhood board is greatly involved in operational details of running the health center. Even though the current activities of the health center board have been characterized as "mostly the housekeeping", board control and involvement have been maintained through the years, including one time period when a board president was accused of mishandling health center funds. Motivation

The strong attachment to the south side of Indianapolis in general and to Fountain Square in particular motivates some persons to participate in collective activities in the area. Although some residents

have climbed out of poverty, they remember those days and how difficult it was to obtain health care, or more recently, how important the health center was to them in provision of health care for them and their families.

There is a sense of helping people who are less fortunate than themselves and making the community a better place for all to live. Residents believe that by increasing satisfaction with the area, there will be less destructive behavior in the neighborhood. One Board member described this as a selfish reason, in that she wanted to make the neighborhood better for herself and her family as well as for others.

Among the currently active members of the Board, the motivation frequently appears to be altruistic with a sense of doing something for "our" people. Reference toward work in the area as a "mission" occurs among the neighborhood members as well as among the professional staff. One current board member had been a missionary in her younger days and described herself as continuing to have a "missionary mentality". Another common motivation is an extension of the work being done in churches into the community. Churches encourage assisting church families in need, and the leap to helping families in need in the community is not difficult.

One Board member's motivation was described as "a burning desire for me to do more and more". She described

her initial participation on the Board as simply sitting and listening to other people talk and not really understanding the content or process of the discussion. It seemed to her that people just made motions and talked a lot. After several years, she became familiar with what was going on, and became an activist on the Board. She also joined other community organizations and recognized the need for collective action in a number of areas. With an expanded view of her world, she began to have her own ideas about how the health center should operate and became a leader rather than a follower.   At this time, she believes her role on the board is to maintain the stability of the health center and to ensure that it is responsive to the needs of the neighborhood people.

Another Board member believed that Board membership had contributed to her personal growth, or as she said "...it helped build my self esteem, made me feel that I was doing some good for the area that I love and it helped me grow as a person."

For some neighborhood people, the reasons for participating are the same as they were in the early days of the health center. The great need for services in the neighborhood such as those provided in by the health center continues. Although there are pockets of middle income people in the area, it continues to be primarily a low income area. In many blocks in the area conditions

have worsened, with more and more houses occupied by-
renters and owned by unconcerned landlords. No private
physicians have established practices in the neighborhood
and the problems with transportation and the provision of
care by the county hospital are little changed. Residents
from these areas are motivated to participate on the board
to ensure that the health center continues to provide
medical care for themselves within "a stone's throw of
where they live". In addition, they recognized that other
persons in the community also need the services.

     Some persons become members because their employer
has a community service requirement. This policy has
generated board members from a local bank and a branch of
the public library. This does not always produce a good
board member. However, in some cases the individual has
become interested in board activities and become a leader
in the group.

     As in any volunteer group, some persons join for the
prestige associated with being on a board. Father Larry
describes these as "the first to burn out", perhaps
because of unreal expectations about board membership and
its benefits. Other board members were less kind in their
descriptions of prestige seeking board members,
emphasizing the need for board members who would complete
necessary tasks and make genuine contributions to board

efforts. Their experience suggests prestige seekers are less likely to be productive board members.

In recent years there have been members and officers from the neighborhood business community. These include a husband and wife who own bookstores in the area and the owner of the music store adjacent to the health center. These members are motivated to maintain the quality of the services for themselves and other neighborhood persons, as well as by concerns about maintaining an economically viable neighborhood.

Institutions of higher education in the city have been a valuable resource in the neighborhood. The Indiana University School of Nursing, Department of Community Health Nursing has periodically assigned graduate students to work in the SouthEast neighborhood. One student was particularly influential in the revitalization of the Fountain Square Neighborhood Association, working closely with the newly elected President to develop the organization.   This had implications for the health center Board, when the president of the neighborhood association became an officer of the health center Board.

Values in Transitions

Gentrification came to part of this neighborhood in the mid 1970s, culminating in the Fletcher Place area being designated a Historic Preservation District in 1980 and the Fountain Square Commercial District in 1984. In

contrast to many areas in the city involved in gentrification, the houses tend to be small workmen's cottaqes and are appealing to single persons or childless families. Gentrification of the local business area has taken the form of "fern bars" and other commercial establishments catering more to the newer residents.

As the population of the area has changed, values have also changed. Interest in the human needs of the people sometimes plays a secondary role to the economic interests in the neighborhood. Investment seem now to be the issue rather than the people and the intrinsic quality of their lives. New residents have purchased houses with the idea of renovating and selling them at a profit. In some cases these new residents have had trouble selling their houses and appear to be putting down roots in the neighborhood. This may again alter the set of values that guide their activities in the neighborhood. The community organization is no longer active and the currently dominant neighborhood organization is the economic development corporation. Role of Local Government

The local city government does not have any direct input into decision making at the health center. However, their influence is felt in other ways. A major role of city government has been to provide funds for operation of the health center. These funds have been funneled through

various components of city government, depending on original source of the funds. Historically, the funds have come through the Health and Hospital Corporation of Marion County (a quasi health department unique to Marion County) . This continues to be a minor source of funding with funds now channeled through the Neighborhood Health Center Program in the Health and Hospital Corporation.

Receipt of funds from local government is not without its problems. At times distribution of these funds was delayed because of in-fighting between Health and Hospital employees and members of departments of city government. In other situations, contracts were not signed promptly due to obscure and inexplicable issues related to the content of the contracts.

Local government has had another supportive role with the health center. The Board is recognized as a power base in the neighborhood that at times has had the capacity to generate considerable political activity. The local representatives to the City-County Council have been helpful with issues related to local government. They have assisted Board members in working on issues such as designating an alley as a street, obtaining an easement, and trash removal.

Senator Lugar continues to be responsive to requests for information or for participation in celebrations of the health center's anniversaries. He has expressed his

support on some legislative issues related to neighborhood
health centers; however, it is difficult to assess his
impact on such legislation. <u>Decision Making Process</u>

An early board member characterized decisions as
being made at two levels. At one level, "the people are
the experts on what hurts and what the needs are and
whether or not what's being done is responding to the
need". At the other level are decisions about how to meet
the need and the management of the programs. For the most
part, the Board has focused on the first area, leaving the
other to administrative and professional staff.

The constitution and bylaws of the organization were
changed in 1976, to eliminate concerns about the
perception that the Board was being "run by a few people".
Changes included specification of a quorum for decision
making rather than a simple majority of those present.
These changes were made at about the time a board member
had been making decisions related to the Health Center by
himself, without consultation or advice of the board.

There have been conflicts but, with a rare exception,
they have been viewed as productive. Former Board
President Alice Good emphasized the importance of open
debate, but maintaining the differences at a "friendly
conflict" level. In some instances she worked with people
outside meetings to assist in resolving differences. The

leadership role is identified with helping to resolve
conflicts and teaching board members how to do this.

In reviewing minutes of meetings throughout the
history of the health center, the strong input of health
center staff is evident. At some meetings, half those
attending were staff. A feeling exists (expressed by-
Board members) that after the renovation and occupation of
the building at 9 01 Shelby, the Board turned over to
Methodist Hospital decision making about health care and
operation of the health center. The Board then focused on
the day to day operation of the building. These were
decisions with which they were more comfortable, falling
within their own experiences.

Control is an issue over which battles may be fought.
Powerful organizations are not accustomed to ceding power
and control to neighborhood folk or, as characterized by
one community worker, "a ragtag group of people". The
current federal guidelines (DHHS) provide a structure and
therefore the potential for a high degree of control by
the community board. In fact, much of that power is not
exercised. One Board member expressed interest in more
exercise of power by the people, but believed the other
Board members were not ready to take control. The level
of control exerted by the people was described as "where
the community is". Part of the problem is that board

members do not perceive themselves as having the education to understand everything discussed and the decisions made.

Several board members (e.g., Selmanoff) believe that Methodist Hospital staff genuinely believe in community control of the health center and have always fostered it. Dr. Benson, the director, is described as always having promoted board participation and having pressed the board to take more responsibility.

The Operations Committee of the Board is expected to review operations of the health center, including staff functioning and hiring personnel. However, "we really don't have much control over the health center functioning at all. Except make sure that it's kept clean and that the patients are satisfied and happy about being taken care of." This is congruent with a past Board member's opinion that the Board was mainly concerned with housekeeping issues.

One area where Board members have insisted on input into decisions is in the hiring of new personnel. Board members believe they are best qualified to judge the interpersonal interaction capabilities of potential staff, that is, that they not be condescending in dealing with patients, not have a "high society doing good" attitude. When potential staff are interviewed by administration representatives, it is made clear that no one will be hired who is not approved by the Board.

After employment, staff are responsible to the administrators who report to the Director, Dr. Benson. The Director is the only person for whom the Board provides direct oversight. He is responsible for the hiring of all other personnel.

Heavy reliance on Board Committees continues to facilitate decision making. Issues are referred to the appropriate committee, with the hope that the committee members will be able to work out a position which it will recommend to the Board for their approval. When an issue is extremely controversial this system has sometimes failed, and it was necessary to "sit in a main meeting and argue it out". This allows everyone who wishes to have input into the decision.

Some discussion of Board business appears to occur outside the meetings. When the issue is a controversial one, the informal interaction increases, especially if the Board members think the decision is "something someone is trying to put over on us". This was one of the few comments that suggested that occasionally the staff are not completely trusted to do what is best for the health center.

Board members have little confidence in themselves to make decisions related to the medical services provided in the health center. Their feeling is that the operation of the health center itself is a technical process to which

they have not very much to contribute so that on their own they are not likely to raise issues such as the number or types of providers or programs that are needed. When technical decisions by the board are required, health center staff provide information to guide the decision. Board members expressed great confidence in the reports given to them by staff members. Selected staff members attend Board meetings and committee meetings and respond to requests for information at that time, or obtain the requested information. This health center has a business agent responsible directly to the Board. He provides information and guidance in decision making related to the building.

Board members feel that their requests for information are, for the most part, met promptly and efficiently. In one exception where requested information was not available, administration was excused because "... maybe they felt we didn't need to know or were so confused they didn't know either..." Considering that this situation involved accounting for funds received and spent, Board members are extremely forgiving of failure to provide information.

Board members express the belief that part of the role of the board member is to ask questions and not make decisions until they understand the issue. In practice, a

few members ask most of the questions and tend to be the "watchdogs" of the Board.

The Board obtains additional information about the functioning of the health center by reviewing patient comments on the care they have received. One Board member is an Outreach Worker in the area for a social service agency and hears first hand of patient problems with the health center. Her invaluable "inside" information helps her to evaluate whether or not services being provided are really meeting the needs of the people. The Board has arranged to have surveys conducted by external organizations in some situations and that information has been used in decision making.

Ownership of the building housing the health center and various social services creates many of the decision making opportunities for the Board and has created particular demands for information. Board members bring with them a wide variety of expertise in building operation and maintenance and usually someone on the board knows how to handle the particular task or identify appropriate workmen or contractors for larger pieces of work. One Board member is a retired music store owner and operator while two other Board members own and operate book stores.

Relatively little information is obtained from sources outside the staff and Board members. In the past

the Council of Indianapolis Neighborhood Health Centers, which operated from June 1980 to at least 1985, provided information about the operation of health centers. Currently no continuing interactions occur between Board members of this health center and boards of other health centers, except as it occurs at HealthNet meetings. Remodeling is one recurring situation that has prompted the Board to seek information from other sources. Board members have traveled to health center sites around the country to determine the applicability of ideas tried in other areas. Effects of HealthNet

Since the start of HealthNet (see Appendix D), there has been a shift of control from the local boards. Some SEHC Board members view this positively because it reduces the scope of decisions they must make. Local Board members continue to have the power to raise objections which are entered into the record, and to make suggestions about organizational directions. The level of control under HealthNet was described as "better control", not lost control. The SouthEast Health Center Board owns its health center building, for which it continues to have sole responsibility. Interactions in the Broader Community

HealthNet provides for regular interaction of SEHC board members with persons from the other two boards.

However, these meetings tend to focus on the operation of the HealthNet organization, rather than as a time for learning from others how to handle issues that are common to all. Interaction at HealthNet has increased awareness of the other groups' problems which may help them to work together.

Selected Board members have opportunities to attend national meetings of the National Association of Community Health Centers (NACHC). These meetings present an opportunity to learn about other health centers throughout the country and how they address issues similar to those faced by SEHC. Unfortunately, these are sporadic events and Board members have not developed a means for maintaining communication with either NACHC or other health centers. Again, staff are relied on to maintain contact with NACHC and channel information to the Board when they think it is appropriate. Membership

The SouthEast Health Center has a general membership of about 90 persons, for which people pay a dollar per year. The general membership then provides the body of people from which the Board is elected. Persons from the general membership are asked to serve on committees and then as committee chairs to determine if they are appropriate for Board membership.

The size of the general membership has varied
depending on the leadership of the Board and their
activity to maintain the membership. When the leaders
offer incentives, such as pitch-in dinners with
entertainment and educational programs, the membership is
maintained at a high level. When no incentives are
offered, membership drops as does attendance at the
quarterly meetings.

As Board member Carolyn Kaptain said, "It's got to be
the people who live in the community go out and grab other
community people and try to get them to come in." This
expresses well the recruitment philosophy at SEHC.
Recruitment of new members is an ongoing activity and is
never an easy task. Many times, after hours have been
spent recruiting and explaining, followed up by phone
calls and letters, individuals who promise to come to a
meeting do not attend. Recruiters can become very
discouraged and question the usefulness of the activity.
The current Board membership is described as top heavy
with older people, with younger people perceived as too
involved with family responsibilities to have time for
Board membership.

Real advantages are perceived in having Board members
coming from the various geographic sub-communities or
church congregations in the neighborhood. This provides
access to numerous groups of people who are potential

board members. The most frequent sources of new members are the friends and acquaintances of current members. These people are seen as more likely to be responsive to social pressure to participate. Even among friends who say they are interested, only one of every two or three will actually become members.

In some instances, specific types of persons are recruited (e.g, financial person) to meet Board needs or to maintain membership that meets federal requirements regarding representativeness of the Board. The biggest problem is to maintain a sufficient number of the correct type of <u>users</u> on the board to meet federal requirements, who will at the same time make a contribution to the Board.

One past president made presentations to various church groups and invited those present to join the organization which usually resulted in new members. Other recruitment activities have focused on the Murphy's store in the neighborhood and the waiting room of the health center which provide, in essence, a captive audience for recruitment. Each place offers a different type of potential board members. Local business people routinely gather at Murphy's for lunch, while health center users are more likely to be low income persons.

One former Board member expressed a negative view of board membership: "There's really not enough

responsibility to being a board member, that you don't
have the say that you feel it important enough"[Briner].
If other people also feel this way, it may explain some of
the difficulty in retaining members. Other members
believe that some people left the board because they "get
fed up with, maybe disagreements". Or others leave,
because of disagreements with decision made by the Board,
and instead of cooperating and trying to work out
differences, they just leave the board.

In general, members believe that most people who
leave the Board do so because of heavy demands on their
time. Board members recognize that priorities change, and
that people may wish to move on to some other volunteer
activity. Some Board members who move out of the
neighborhood may wish to become involved in their new
neighborhoods.

The notion of "burnout" is an accepted phenomenon.
When Board members have been intensely involved in Board
activities for a number of years, they may be seeking a
less active role which can only be achieved by resigning
from the Board. Burnout was also described as a problem
for professional staff involved in the development of the
center. Community organizations are seen as very draining
on personal resources, and as not restocking those
resources in any way.

Some members were reluctant to join in the first place. Whether their membership was a function of "arm twisting" by a friend or pressure by an employer, if they do not quickly become involved in the activities, they are likely to be on the board only a short time.

OTHER NEIGHBORHOOD ORGANIZATIONS

When Sells and Kohls began organizing the neighborhood, efforts were aimed at building a broad based organization, which became the Fletcher Place Neighborhood Organization. They followed this with the organizing related to the health center and housing issues. These organizations were frequently confrontative in their dealings with local authorities and much of their success was attributed to their providing a forum at which neighborhood people were able to express their concerns to authorities.

When the health center began to outgrow its first home and the opportunity to obtain a large building appeared, this provided an opportunity to obtain additional services for the neighborhood. Responsibility for such a large building was seen by some persons to be a larger undertaking than a neighborhood group could handle. However, the same professionals were there to help in this project as had helped to develop the health center. Some of the same people who were on the health center board

formed another neighborhood group and went on to develop a
multiservice center in this building. This organization,
the SouthEast Multiservice Center (SEMSC) brought to the
area a variety of needed services for the area which had
previously been scattered throughout the city.

Another subgroup developed the United South Side
Community Organization (USCO), an organization focused on
community organizing and serving as an umbrella
organization for community groups. Numerous block clubs
were developed and functioned within the umbrella
organization. Although these occurred after the
development of the health center, they seem not to be
spinoffs of the health center. Actually the reverse seems
to be true. As Father Larry Voelker described it, "It's
hard to describe an organization that came first as a
spinoff, but conceptually the health center was only a
portion of a broader spectrum of community based services
envisioned in the neighborhood." In any case, development
of the health center was a success on which other
organizing activities built.

Although the multiservice center and the United
Southside Community Organization (USCO) were started by
many of the same people involved in the health center,
each effort involved different subgroups and philosophies
from within the health center group. The multiservice
center was primarily the effort of a conservative element

121

in the group, while the activists and Alinsky oriented

members developed USCO. These differences were reflected

in the actions of each group. The multiservice center

focused on bringing in services to care for the people. On

the other hand, USCO became politically active and

sometimes criticized the city administration supported by

members of the multiservice center board. The

professional staff recognized the value of separating

service provision from social activism. However, this

created some tensions between the grassroots members of

the USCO, SEMSC, and SEHC boards.

In the long run, the health center and the

multiservice center have endured while other organizations

have diminished in power, or completely disappeared from

the scene. This may be partly the function of reduced

support by outsiders for professional staff for

organizing, leadership development, and social activism.

Another explanation for the failure of the

neighborhood folk to develop additional organizations may

be attributed to the scarcity of leaders in the

neighborhood. When those available as leaders are

concerned over maintaining a valuable organization they

have little energy left for starting new organizations,

even when they see unmet needs.

More recently, a community economic development

corporation and a housing and historic preservation group

have been formed. These efforts may represent a shift of
focus to more material aspects of life and appear to be
primarily the work of a different set of neighborhood
residents. However, their success suggests that the
neighborhood continues to provide the setting for work
toward valued collective goods.

Another new organization, the Fletcher Place-Fountain
Square Investment Corporation, has been involved in
helping people get funds to "fix up/paint up" existing
homes or for loans to buy houses. The development of this
group appears to be independent of the work of the health
center board.

THREATS TO CONTINUED COLLECTIVE ACTION A major
threat to the organization occurred during 1976-77 when a
member of the organization was involved in mismanagement
of health center funds. During the time period leading to
this event, the board's activities were less characterized
by their collective nature than by the activities of one
member, Lester Neal, who was part of the structure of the
political elites in the city. Board members had allowed
him to have a large amount of discretion in board matters
because, as a local political party official, he had been
very successful in obtaining anything needed from local
government. As it turned out, one of the decisions Neal
made on his own was to borrow

money in the name of the health center without requesting
approval of the board or even informing them that he had
done so. The money was not used for health center
expenses, but was diverted to Neal's personal accounts.
Later, he was indicted and plead guilty to criminal
charges related to these activities.

   Before the malfeasance was discovered, most board
members had unquestioned faith in Neal. Although some
persons had questions in their own minds about ceding so
much authority to one person, no one had openly questioned
his trustworthiness. One board member (Selmanoff)
expressed concern that the board had been negligent in
allowing the control of the board to be shifted to one
person. In retrospect, it was clear that the board really
was not in control and information needed for decisions
was not given to them. Because things appeared to be
running smoothly, Neal's actions were not challenged.

   When the problem was discovered, board members
disagreed on how it should be handled. Legal advisors
suggested the board should deny knowledge and
responsibility for what had occurred. The Board
president, on the other hand, maintained that it was clear
that the money was on the books and they had a moral
responsibility to admit it was there. The lawyer argued
that if they admitted the money had been there, they would
have to pay it back. As a result of the disagreement, the

Board president resigned and left the board, never to
return. [3] The Board continued to maintain its position
that they were not responsible for repayment of the
money, and the loans were eventually written off by the
bank.

SUMMARY

Several factors can be identified that contributed to
the success of the group that started the South East
Health Center and of the Board that continues to operate
the center. Neighborhood factors provide a supportive
environment for collective action. The presence of the
Fountain Square commercial area, the large number of
churches, and other neighborhood groups all provide
numerous opportunities for interaction among the residents.

Without the willingness of neighborhood people to
work long hours for a number of months, the health center
would never have been started. Having won a battle with
government regarding the interstate highway, residents had
developed a belief in themselves and their ability to work
together. Among these people there was a concern for
others that sustained them when progress toward their goal
was slow. Although religious beliefs about caring for
others fueled some neighborhood activists, a general sense

of concern for others is pervasive throughout the neighborhood.

From the beginning, group members agreed about their goal and the means to achieve that goal. It was clear to residents that neighborhood medical services were inadequate and that they were unlikely to be able to attract a private physician to the area. The choice of a health center to meet that need was supported by the people. Utilization by an increased number of board members as well as other neighborhood residents supports the health center as today's preferred method for meeting this neighborhood's health care needs.

The center started in the late sixties when many neighborhoods were beginning to make demands for additional or decentralized services and to participate more in their operation. However, it is unlikely the health center would have started without the commitment of the Methodist Church to urban neighborhoods designated as mission areas. Necessary resources were made available to this area as a result of its designation as a mission area, and provided the funds and personnel for organizing activities. Individual religious leaders, especially Sells and Kohls, were committed to improving neighborhood conditions and to empowering local residents. Sells and Kohls brought a level of skills that would not otherwise have been available to the neighborhood. Church officials

126

were highly supportive of the activities and demonstrated considerable tolerance of radical behavior on the part of Fletcher Place Community Center Staff. One wonders if such behaviors would be tolerated by later church officials.

Local leadership, supplemented by nonresident members, has sustained the organization through the years during routine operation of the health center . The health center board operated during these times with a minimum number of members and carefully monitored the environment. When needed, a larger group of people could be regenerated. Board members have grown in their experience and knowledge from the long association with professional administrators and experience little professional dominance in issues related to the building.

An institutional base for the health center was provided by Methodist Hospital. Their philosophy and religious orientation have supported their activities in the health center. The hospital played an essential role by providing physicians and assuming responsibility for medical services. In addition, they were a large enough organization to carry the health center during gaps in funding and to absorb some of the costs of the center during financial crises. On the other hand, such a strong organizational base may have precluded the Board from fully developing to its maximum potential.

NOTES

1. Social and economic data from the 19 9 0 census were
   not yet available.

2. The issue of boundaries continues as an issue for
   board members of this health center. Among the three
   centers studied, only SouthEast board members suggest
   that persons outside their boundaries should be
   excluded from service.

3. Fortunately, she did agree to be interviewed and
   spoke freely about her experience on the board.

CHAPTER FOUR

COLLECTIVE ACTION IN BARRINGTON

129

CHAPTER FOUR COLLECTIVE ACTION

IN BARRINGTON

The Barrington Heights Apartments opened in 19 50 and were
intended to provide housing for working class blacks and
create an "ideal type of environment", that is, clean
adequate housing in a safe neighborhood. The complex
contained 7 00 one-story apartments and was built by
private business. By 19 68, the apartment complex had
deteriorated and was a detriment rather than an asset to
the community. In an attempt to reclaim the original
builders' dream, the project was purchased by Flanner
House Homes, a non-profit organization that had a
successful history of assisting low income neighborhoods
with housing problems, with plans to renovate the old
apartment buildings and build new ones. However, the
deterioration was so great that little progress was made.
The poor physical condition of the buildings was matched
by the poor quality of life experienced by the residents
of the complex, including high rates of crime, drug abuse,
and unemployment. Residents concerned about these
problems and the perceived inadequacy of police protection
felt powerless to effect or demand change. One
neighborhood resident characterized the neighborhood as
"...a kind of forgotten area all through the years". When

local government or business people talk about improvements in the area, neighborhood folk have little confidence that the projects will ever occur. In discussing a proposed housing development a resident expressed his doubts and those of other residents as "Nobody believes it until they see it, until they have some tangible evidence".

THE NEIGHBORHOOD CONTEXT

It was within this environment that the Watoto-Wa-Simbas emerged. Watoto-Wa-Simbas means young lions in Swahili and the group was composed of young black men from the neighborhood. The Watoto-Wa-Simbas were "trying to be responsive to the needs of the community" (Watts) and planned to address unemployment, crime, and drug problems. As they pursued these plans, the need for health care services in the area became apparent. Physical Environment

The Barrington neighborhood is in the southeastern part of Center Township, just north of the independent city of Beech Grove (see Figure 4.1). The area is crossed by several major thoroughfares and sets of railroad tracks. Industrial areas are located along these man-made dividers in the neighborhood. The effect is creation of small pockets, containing residential areas which are somewhat isolated from each other.

131
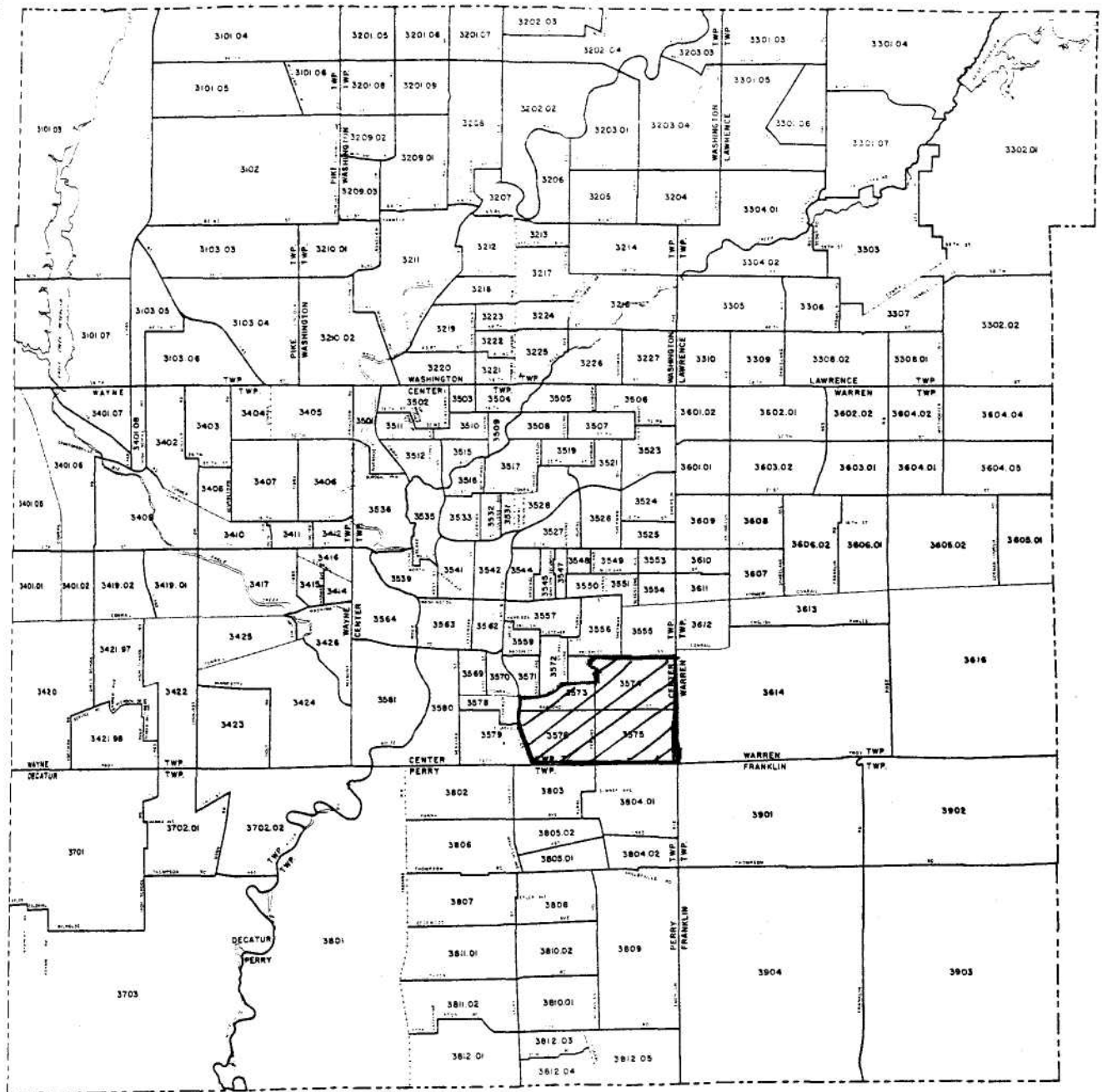
1990 CENSUS TRACTS

Figure 4.1 Barrington Neighborhood.

Both light and heavy industries are in the
neighborhood and are owned by corporations from outside
the community. A major visible feature of the
neighborhood are the large grain elevators at the corner
of Sherman and Raymond. While imposing in appearance,
they serve as an attraction for rats and other rodents.
The corporations represented in the neighborhood have
demonstrated little, if any, interest in the neighborhood.
Small commercial areas are scattered throughout the
neighborhood, but in some cases are abandoned and serve
only to attract litter.

The diversity in the area extends beyond the
industrial, commercial, and residential areas. Although
Barrington has long been part of Indianapolis, on occasion
one may still see a horse in a field or a privy in a back
yard. In 1990, sewers and full utilities were installed
in parts of the neighborhood for the first time. Few
other changes have occurred in the area in the last 20
years. While one tenant may move into an empty shop,
another moves out, leaving a comparable space empty. The
grain elevators and the rail yards continue to be stable
features of the neighborhood.

Bethel Park is a positive feature of the neighborhood
and serves as a major gathering place for the young
people. As part of the City Parks and Recreation
Department system, Bethel Park contains a swimming pool

and covered basketball courts as well as a playground and picnic area. The park is used as the site of major community events such as the "southside reunion". In newspaper articles in 1991, the park was cited as one of the best in the city. Housing

The area was platted and housing developed as early as 1875. Development of the railroads and industries on the south side of Indianapolis created incentives for building houses for the workmen, small single story buildings on relatively small lots. The area seems not to have benefited from the upsurge in housing construction that occurred after World War I in most areas of the city. However, many small, one story brick or frame post-World War II homes can be seen throughout the area. The construction of the Barrington Apartments in the fifties provided much needed rental housing in the area. Other apartments aimed at low income or elderly persons were also built in the area. The Brookside Apartments for the elderly have been well maintained and continue to provide subsidized housing for the elderly. In contrast, construction and sale of new single family homes continued throughout the early seventies only in the extreme southern part of the area.

The area historically has housed working class people and continues to do so in many of the single family homes.

134

In addition to apartment complexes providing subsidized housing, public housing projects were erected in the neighborhood during the late sixties. The public housing projects are in varying states of repair and only partially occupied. Two of the projects have recently benefited from refurbishing, precipitated by a shift in the management of public housing projects in the city from an independent housing authority to a municipal corporation.   Some of the apartments intended to provide subsidized housing for low income families had fallen into such extreme disrepair that they were demolished. People

For decades there have been several sub-communities of black working class families living in the Barrington neighborhood. Residents characterize the neighborhood as "always having been integrated". The home where one black, neighborhood woman (Pamela Hall) was interviewed had been given to her grandparents by their parents as a wedding gift. She had lived in the house all her life (39 years). Families in the Barrington neighborhood have formed a long established community and report that a "strong community feeling" has always existed.[1] Many of the black residents came from Tennessee and Kentucky and have felt bound together by ties based on their geographic origins. Charles Crenshaw, a Board member and a retiree from the Chrysler Corporation, was born and raised in the

neighborhood. His father and several uncles had migrated from Kentucky about 65 years ago, seeking employment in industries located on the South Side. They all settled in the Barrington area.

The total population in Barrington increased between 1960 and 1970 and since that time shows a trend to a declining population (see Table 4.1). The decrease in the percent of black population between 1960 and 1970 is a real decrease in terms of number of black residents. Apparently while black residents were moving into the housing projects in the area from other parts of the city, some established black residents were leaving. In examining data for the specific in the area it becomes apparent that, presently, the black residents are disbursed more widely throughout the area and not concentrated in a few subcommunities.

Table 4.1
Barrington Population Characteristics

	1960	1970	1980	1990
Total %	17,894	21 ,552	22,103	20,060
Black	20.7	17.0	21.2	22.8

As a result of the man-made barriers in the neighborhood, four to five block areas of houses are separated from each other by major thoroughfares, railroad tracks, industry, and grain silos. On some streets,

access to the main thoroughfare is blocked and the street serves as a barrier rather than a facilitator of transportation. The divisiveness sometimes carries over to how the individuals group themselves into organizations and take positions on issues. The black residents tended to cluster in small sub-communities to which they give their primary allegiance. The sub-communities included Norwood (on Prospect), Love Town (Bethel and Minnesota area), Dog Town (south of Bethel), and Scratch Town (Keystone, Calvin, Churchman and Zwanely). Black Barrington residents take great pride in their south side neighborhood and considered themselves to be different from blacks living in other neighborhoods. One expression of this pride is the two-day Southside Reunion, held every four or five years and developed by a loose coalition of representatives of the sub-communities.

Old time residents continue to have great pride in their community, but have been willing to take on the concerns of the residents of the housing projects, recognizing the newcomers' problems as being neighborhood problems. Neighborhood organizations are not apparent among the white residents, although they do not appear to be intentionally excluded from the other organizations.

Construction of the public housing projects in the neighborhood in 1968 attracted a population (primarily black at first) which had different life experiences than

137

long-time neighborhood residents. The new residents were usually from the north side of town and unemployed, and had moved to Indianapolis from other cities rather than rural areas. One board member who has lived in a public housing project for the past 16 years, moved to Indianapolis from St. Louis and had formerly lived on the north side of Indianapolis.

When the Clearstream Apartments (one of the public housing projects) opened, residents from Lockefield Gardens, a public housing project near downtown Indianapolis, were relocated to Clearstream. This wholesale relocation is important because it moved people with a group identity which may have been a barrier to integration of the individuals into the Barrington community. When residents moved into the Clearstream Apartments they were isolated from the rest of the community. The apartment complex was built at the corner of two major four-lane thoroughfares. Railroad tracks are to the west of the complex and the street is elevated over the tracks, physically and visually cutting off the complex. The fourth side is bounded by a small stream and marshy area that again decreases the likelihood of any interaction with persons outside the complex. Other public housing complexes that were built in the area are somewhat less isolated, but set off by intentional barriers such as high fences.

New residents in the public housing projects complained about the "rural" nature of the area and frequently said it was too far out. They would have preferred to have been closer to the downtown area. When the units were first occupied, no city bus service was available and residents were unable to obtain needed services, including health care, that they had been accustomed to using in the center of the city.

The sub-communities of Blacks and each of the housing projects are surrounded by white residential areas. The predominantly white areas tend to be of higher socioeconomic status than the predominantly black areas. Many residents of the Barrington community, black and white, receive public welfare assistance or SSI.

Institutions

During the sixties, Barrington lacked many of the social and health related services provided by multiservice centers in other neighborhoods. Service providers considered the area to be part of the SouthEast Multiservice Center area, while black Barrington residents believed they were not welcome at that location. Service needs were for the most part met by local organizations or by going downtown to main offices of the services.

Churches play a major role in the lives of Barrington residents. About 2 0 independent churches are in the neighborhood and vary in size from small storefronts to

large buildings with congregations of about 2 00. The churches focus on the spiritual needs of the residents, and except for food pantries have seldom been involved in community residents' other needs.

Each of the three public housing complexes in the neighborhood has a tenants' council. The councils, at times, articulate the needs of the residents and make demands on other institutions. The councils also provide opportunities for residents to develop leadership skills and to participate in citywide meetings.

Saint Francis Hospital in Beech Grove is adjacent to the area and is the closest hospital. Although one neighborhood resident acknowledged the hospital as available for emergencies, some residents claim that black persons are not welcome there and residents are more likely to go to the county hospital, Wishard, for emergency services.

The Department of Public Health provides public health nursing services for the neighborhood from an office in the Fountain Square area. Public health nurses are in schools in the area on a regular schedule, yet no relationship has existed between Barrington Health Center and this division of the health department.

ORGANIZING THE NEIGHBORHOOD

During the early seventies, the United Southside Community Organization (USCO) was developed as an umbrella organization for human service organizations on the Southside of Indianapolis. USCO had been successful in obtaining construction of a drainage ditch in Barrington that relieved problems created by storm water and had successfully campaigned for sidewalks in part of the area after a child was hit by an automobile and killed. Despite these benefits for their neighborhood, Barrington residents believed that USCO was only interested in obtaining services and resources for the Fountain Square neighborhood. A group of young black men from Barrington broke away from USCO and obtained a grant from the Lilly Endowment to start a club to address youth related issues in the neighborhood. This was the beginning of the Watoto-Wa-Simbas who later pressed demands for a health center in the Barrington area. Charles Crenshaw continued as an active member in USCO and as he put it, "...got the flack because I belonged to USCO".

The Watoto-Wa-Simbas organization was modeled on the Black Panthers organization and had four officers: chairman, interior minister, secretary/ treasurer, and information minister. Officers were elected annually by

membership vote (Rich, 1976, p.171).[2] An extensive

committee structure was developed, with each committee to

address a different issue. Jerry Watts, secretary of the

original group, described the organization as filling a

void, the lack of leadership in the Barrington community.

At the time the organization developed, no organization

in the neighborhood was accepted by the residents as a

proponent of their views. The groups in the neighborhood

had worked independently of each other and in some cases

one community group would undercut projects attempted by

another community group. Although representing only the

black segment of the community, the new group was an

attempt to address the problems they shared.

The organization appears to have been created with

goals and structures consistent with the leaders' personal

dispositions and definitions of community problems (Rich,

1976, p.249) and these were consistent with those of other

black neighborhood residents. Watoto leaders saw

neighborhood problems as the reflection of a lack of

political and economic power. Very few city services were

being provided in the community and no local organization

was available to pressure the system to respond to

community needs. The Watoto organization viewed itself as

a broker that would identify the needs of the

neighborhood, identify the appropriate agency in the

existing system, and see that the agency responded to the

142

neighborhood's needs. The Watotos were not interested in direct involvement in provision of services or in creating a new service system in the area. <u>Membership</u>

The Watoto-Wa-Simba organization did not seek mass participation in regular affairs, but mobilized the resources needed to solve specific problems. Leadership of the group recognized that pressure must be brought on the larger system (i.e., external resources needed) if needs were to be met, since resources were scarce in the community. Membership was limited and new members were nominated by current members and required approval of two thirds of the membership. By controlling membership in the organization, the group was able to restrict membership to highly motivated individuals (Rich, 1976). The majority of the members (40 of 46) were active participants in the organization (Rich, p.171). A relatively small elite group could take positions and actions that furthered the group's cause. The organization took actions intended to alter the services delivered to the community, not just to satisfy individual members' needs. Participation was viewed as a means to goals, not an end in itself (Rich, 1976, p.249). The Watotos sought to create a sense of community identity and political efficacy, which were seen as necessary tools for the acquisition of political influence.

143

Although the membership was limited to those selected
by current members, it included a diverse group of people.
Other organizations might have been unwilling to allow
some of the members on their boards because they were very
vocal or might "say some things that might not be well
pleasing to the ear" (J.Watts). While other organizations
may have steered away from such folks, the Watotos
recognized that these people had "street smarts" and were
the leaders of certain segments of the neighborhood
population. Such members increased the credibility of the
organization within the community and prepared the way for
the expression of needs of a segment of the community that
sometimes had no forum for its issues. The organization
and its members provided access to the "system" for a
segment of the population that was relatively powerless,
and in exchange were granted access to additional people
who were needed for the strategies they used.

Officers of the Watoto-Wa-Simbas were classified by
Rich (1976,p.248) as protesters. The leadership was not
racially integrated and was composed mostly of persons of
a lower socioeconomic status. They were concerned
primarily with services the neighborhood could not provide
for itself, but viewed their relationship with government
as an adversarial one. As a group representing a nearly
all black economically depressed community, the adversary

relationship was a reasonable choice as a route to power for the community.

Indigenous leadership is an essential component of community based organizations. The Watotos were fortunate that there were two young men (Stanley Strader and Jerry Watts) who had some training and experience with community groups. They were able to develop the organization and bring together this group of young men and "put some type of method to the madness" (J.Watts). Motivation

Motivation to participate in the Watoto organization and its activities stemmed from several sources. The strong community feeling encouraged the young men to do something for the people in their neighborhood. The feeling that outsiders were using the community or not being attentive to Barrington's needs strengthened the perceived importance of the organization. The use of data related to the Barrington community to obtain services that were not then provided within the specific area may be construed as one of those instances where the broader community is seen as a threat to the Barrington community around which community members rally.

Another view held by one of the leaders of the group (Jerry Watts) was that "Most people do things for utilitarian purposes, even friendships are utilitarian, otherwise, why would you have them?". The leaders

145

understood this broad view of utilitarianism and attended to it by addressing the personal agendas of people participating for those reasons. One former member described motivation as stemming from what he considered "pure altruism". However, he went on to suggest that from his point of view altruism, also served utilitarian purposes.

In contrast, the same leader believed that community organizations were filling a void created by the failure of churches in the community to meet the social responsibilities of organized religious groups. The churches were described as "so far removed from those realities. And sometimes their philosophical or religious bent is such that they forget about the teachings of Christ, in terms of doing things that need to be done. And they think that their responsibility is dealing with the spiritual ministry and forgetting about the social ministry". The churches as a group were expected not to be bound by utilitarian guidelines as to what was good for them as an organization, but to minister to the needs of the people. Focus and Strategies

The Watotos identified the interests and needs of area residents and mobilized the resources necessary to promote those interests. The original thrust of the organization was in dealing with the problems related to

the young people in the neighborhood. It became evident
quickly that the youth problem was a manifestation of
larger community problems and that a holistic perspective
was called for to address the needs of the community. The
organization adopted a philosophy of "from the cradle to
the grave". When the multitude of social ills present in
the neighborhood was considered, among them was health.

The methods used by the Watoto-Wa-Simbas were not
always the ones organizations and agencies were
accustomed, but for this neighborhood and group and the
times (early seventies) were appropriate means to access
the power structure. Two of the leaders have been
characterized as "students of the modified Alinsky school
of organization". Their approach to community organizing
integrated ideas from Saul Alinsky, Stokely Carmichael,
Dr. Martin Luther King, and Malcolm X.

A variety of techniques was used to obtain resources
from city agencies. One technique used was a "modified
skin game", or as described by Jerry Watts, "It was really
a con". When dealing with the power structure,
alternatives would be offered to officials. First, just
to get the officials attention, they would send in a black
man "with a five-foot afro, wearing a dashiki, and a 52
caliber bullet hung around his neck" to talk about the
issues in the community. He would be followed by a clean
shaven black man, "three-pieced to the bone, buttoned

down, attache case, program in hand." The approach
offered an alternative for the officials and at the same
time put pressure on them to respond to requests. The
presentation of an alternative program by a seemingly
rational man (one perceived to be more like themselves)
allowed officials to avoid the threatened confrontation
and resulted in services for the community. Watts
maintains this was a true con game in that the perceived
threats of confrontation would not likely have been
carried out.

The clever manipulation of the system plus the
ability to "put the people on the streets" were powerful
tools in the early seventies. At one point the Watotos
wanted to use the concession stand at the local swimming
pool as a mechanism for an employment training program. At
that time, concession contracts were let by bid with the
contract for all concession stands in the city going to
one bidder. In order to persuade the Parks and Recreation
Department to alter the process, a group of the Watotos
went to the director's office and staged a sit-in. When
television and newspaper reporters arrived to cover the
event, the Parks and Recreation Director capitulated and
use of the stand was given to the Watotos. <u>Resistance in
the Larger System</u>

Creation of an organization to increase
responsiveness of the system to the Barrington

neighborhood's needs did not necessarily mean the organization would be accepted by the system as spokesperson for the area. The Model Cities program representatives viewed the United South Side Community Organization (USCO) as the umbrella organization through which requests from the sub-communities should be channeled. The Watotos believed that USCO used the statistics from the Barrington area to document the high level of needs in the entire South Side, and then provided the services in locations on the South Side, outside the Barrington neighborhood. Although having a limited membership, the Watotos involved large numbers of neighborhood residents in their attempts to gain legitimation and acceptance by city officials as representing the community. Local meetings involving residents were held and groups of residents were bused to City-Council meetings. Their persistent efforts and the support of large numbers of community people paid off and the Watotos were able to convince the authorities that they were legitimate spokespersons for an area whose needs were not being addressed through USCO.

STARTING THE HEALTH CENTER

A committee was established within the Watoto-Wa-Simba organization to address the health care needs of the neighborhood. Although services were available at Wishard

Hospital and at Southeast Health Center (SEHC) neither was easily accessible by public transportation. Indeed, although the SEHC was only a few miles away, one had to take a bus downtown, transfer across to another route, and then come back south to the center. Additionally, among black residents of Barrington, SEHC was perceived as "for whites". The Watotos understood well the problems of obtaining health care and knew that private medical practitioners would be unwilling to move into an area in such dire economic straits. Even if a physician had moved into the area, residents did not have money to pay for private medical care.

Because they did not see themselves as the providers of services, the group sought a provider for health care. Several hospitals were approached in 1972, including Methodist Hospital, but none were interested in providing health services in Barrington. The Watotos next carried their request to H & H, as they believed provision of health services for indigent persons was part of the mission of that organization. H & H refused the request. Undaunted, the Watotos changed the request into a demand that was carried to city government. A legend has developed around the tactics used to influence the city The legend includes describing the Watotos as a motorcycle gang whose members rode their motorcycles around the City-County Building until Mayor Lugar agreed to provide health

150

care services in the neighborhood. Another version of the
legend has the Watotos sitting in the Mayor's office until
services were promised.[3] In any event, the tactics were
successful and in response to the demands, a neighborhood
health center was started and operated in the area by the
Health and Hospital Corporation [4].

The health center first opened in October 197 2 and
was operated by the H & H. It was located in some vacant
units of the Barrington Apartments. Little information is
available about the first years of service due to two
events. A fire in the mid seventies destroyed the
building housing the Watoto-Wa-Simba's records and none of
were salvaged. Reorganization of the H & H changed the
positions and roles of the personnel responsible for the
operation of the health center and they were not available
for interviews.   In 1974[5] the Health Center moved to
Bethel Avenue, where it continues to operate. During the
time it has been there it has expanded, increasing the
number of square feet it occupies in the building.

An advisory board for the health center was developed
by H & H staff, and one member of the Watoto-Wa-Simbas
served on the board along with other neighborhood
residents. One of the functions of the advisory board was
to broaden its base by including other community members
and thereby strengthen the health center's position in the
neighborhood. Representation from different segments of

the community was sought and included senior citizens, representatives from the different housing projects, and the principal of an elementary school. Once the health care services were obtained, there appears to have been minimal regular involvement of the Watotos.

During the time H & H operated the health center, the advisory board had almost no function and gradually stopped meeting. However, crises such as threatened closing of the health center (see below) reactivated the Board. H & H support for a community board was minimal and did not include any direct support of the Board. Residents began to talk among themselves about the health center's lack of responsiveness to their needs and were supported by an independent community study in 1977 that produced a recommendation that a community board be formed.[6]

Decreased participation by the Watotos on the health center Board did not mean declining interest in the health center. When a threat to continued operation of the health center occurred, the Watotos rallied to the cause. After the health center had been in operation for a year or two, a reduction in the funds available brought about discussion at the city level of discontinuing services at the Barrington Health Center. When invited to speak to a committee of the City-County Council, the Watotos responded by taking with them two buses loaded with

neighborhood people, "all kinds of people, from eight to 85". There were old people on crutches and young folks "who looked kind of wild". The council committee members were unused to seeing so many blacks and such a variety of them at their meetings. It was only a short time until there were sheriff's deputies stationed around the walls. However, this was just a version of the "skin game" described above. Although the councilmen perceived a threat to their safety, there were no plans by the community people to take action of any kind. A Watoto leader (Watts) believes that it was the careful use of the "skin game" and the show of numbers that kept the center open.

The health center was closed for a brief time in 1977 during reorganization of the Executive Division of H & H, which had responsibility for the Barrington Health Center. The administrator who was responsible for Barrington has been characterized as "not doing a very effective job". He was shifted to another position within the H & H and the division which had responsibility for administering the health center was deleted from the organization leaving the health center without administrative oversight. A representative of the Mayor contacted Jack Hahn of Methodist Hospital and requested that Methodist take responsibility for Barrington. The contract was given to Methodist Hospital Ambulatory Services to provide

administrative and medical services. Mr. Hahn agreed for
Methodist to do this on an interim basis until "the city
got its act together (Benson).[7] Dale Benson, the medical
director at SEHC at the time, has described the event as
"Barrington got dumped in our laps". However, Benson and
others at the hospital believed that "there was a real
need for Barrington Health Center ....and it didn't seem
reasonable to close it down."

When H & H discontinued administering BHC, they also
discontinued funding. Methodist Hospital funded the
health center for about six months before they located
funding for the center from the federal government through
Section 330 of PL 94-63, the Community Health Center Act.
BHC was the first center in the city to receive funds from
this source.

DEVELOPING A NEW ADVISORY BOARD

During the six months of operation with Methodist
funds, the Methodist Hospital director of neighborhood
health centers assigned a staff member, Chaplain Tom
Adams, to develop a neighborhood advisory board to make it
consistent with the other centers operated by Methodist.
As Adams began to develop the board he was unable to
identify any overall leadership in the community. Nothing
appeared to unite the community, nor were any leaders
accepted by most residents in the area. He was warned by

154

some residents that anyone who tried to take leadership in the community was undercut by small "pockets" of people in the community and the attempts to unite the community were sabotaged.

In an effort to develop a board where people would work together, Adams set out to build on the existing organizations and factions, obtaining board members from each of the groups in the community. Existing organizations included the tenant councils of the housing projects, block clubs, and churches. The board was conceptualized as a microcosm of the community, representative of the various groups which had opposing opinions and therefore representative of the persons in the community. Persons representing different territorial concerns were on the board and their issues surfaced during discussions related to the health center. Some of the infighting that occurred later on the board has been attributed to the formation of a new group, with its associated struggles over who is going to be the leader and who is not. For whatever reason, the struggles on this board have continued through the years.

Among the existing groups, the churches were notable in their failure to respond to requests for participation. Numerous attempts were made to contact ministers through letters, at their churches, and through the neighborhood ministerial association, but no members were recruited

155

from the churches. Barrington is an area where many
people attend church, so the individuals from other groups
may also have represented the churches. However, there
was no commitment from the churches as institutions to
support the health center and its efforts.

St Francis Hospital, although near by, has not been
involved with the health center, none of the persons
interviewed or the historic documents have mentioned
approaches to St. Francis Hospital for participation on
the Board or in other ways at the health center. The role
of Methodist Hospital in the process may have precluded
inclusion of other health care institutions.

The first meeting of the new BHC Board was held in
May 1978, and was attended by 14 persons. Those attending
agreed that residents of the neighborhood were not aware
of the existence of the health center, and an open house
was planned to inform neighborhood residents about the
health center and the opportunity to participate on the
board. Meetings were held every two weeks to plan for the
open house. Other neighborhood concerns discussed at the
first few meetings were the need for transportation to the
center, hours of operation, and the patient-physician
relationship. During the first 18 months of this new
board, three former Watotos were active members of the
board. Stan Strader was chair of the membership committee
and Tack Williams and Dennis Hassan are listed as members

in regular attendance at meetings. Some of the other members of the new board had participated on the first board at Barrington Health Center.

The open house resulted in new members in addition to those recruited from other groups. One of the new members recruited at this event was a recent widower (Carl Glassburn) searching for activities to fill his time. He made major contributions to the board, bringing both management and leadership skills and serving at different times as president, secretary, and treasurer.

The first set of bylaws was adopted in August 1978 and were modeled after the original bylaws at Southeast Health Center. Membership was open to anyone willing to sign a membership pledge and willing to attend meetings. A quorum consisted of a majority of those present. Officers were elected in November 1978 and were to serve until the end of 1979. The staff person (chaplain) assigned to the board was seen as a facilitator of the meeting and communication.

The advisory board was conceptualized as being the "eyes and ears of the community" and as serving as a mechanism for information exchange. It was to be an open organization with no limit on membership and anyone who came to a meeting was a member. Attendance varied widely, sometimes only officers were present. Other members were inconsistent in their attendance with one set of members

157

at a meeting one month, and another set the next. The
lack of continuity among the members increased reliance on
staff and the officers to be knowledgeable about issues.
Staff considered Advisory Board positions on issues in
their decision making and translated them into policy.
Content of board meetings over the next 6 years included
decisions related to the Payment In Advance (PIA)
procedure, public relations, fundraising events for the
board, and approval of changes in fee schedules
recommended by staff. From the minutes it appears that
staff also voted in the meetings. In many minutes no
decisions were noted, but many topics were discussed at
length. Recurring issues were staff attitudes toward
patients, the transportation system for the health center,
membership in general and in particular meeting the needs
of board members who were ill, social problems in the
neighborhood, and ways of influencing local government.
Community concerns or "gripes" about health and health
care could be expressed at the meetings, and health center
staff could also give information to board members to
carry back to their subgroup in the community. People
were free to come to any board meeting and express their
concerns or feelings about the health center. Board
members had little or no responsibility to take action to
address the concerns raised at board meetings. Health

center staff were expected to be responsive to issues raised at meetings.

From 1978 to about 1983, about $500 per year from health center operating funds was made available to the Barrington Health Center Board. As the years passed, Board members viewed this money as a "right". The money was used to fund membership related activities such as food for the annual Christmas dinner, plaques for outgoing officers, flowers or funds for members who had a death in the family, and as seed money for fund raising activities. Board fund raising resulted in only small amounts of money that was used in the same manner as the $500.

Decisions related to allocation of Board funds and determining the appropriateness of requests for expenditures sometimes created ill feelings among the Board members. Members who were also tenant council members sometimes requested Board contributions toward events for persons in one complex or the other, for example, a trip to King's Island for children in the Clearstream Housing Complex. While some board members would have responded positively to such requests, other members believed it was unfair to fund projects in one complex and not in the others. Most requests of this nature were rejected.

In the early days of the Board attorneys and teachers, along with the staff, provided expertise on the

159

board and facilitated decision making. At other times,
opinions were solicited from persons identified by Rilda
LaVelle as "other educated people". Board members also
sought information, calling on their resources in local
government or other agencies. Staff members provided much
information needed for decision making, and early
decisions were characterized by one board member as being
"just about what they (staff) asked us to do, because it
made sense to us."

BECOMING A POLICY MAKING BOARD

Funding obtained from Section 330 brought with it
the requirement that there be a policy board rather than
an advisory board, which was a new role for the
neighborhood residents. Federal requirements set a limit
on board membership (25 members) and proscribe the type of
persons who can be on the board. At times recruitment
efforts must focus on someone who is a user of the center
or of a certain age or race in order to maintain the
correct balance of membership.

Altering the board from an open organization to one
with decision making responsibility has been a difficult
transition. Although the board has had responsibility for
policy making for eight years, such actions are a struggle
for the board. Some members would like to return to the
"old days" when the board was not involved in policy

making and could spend more time addressing social and non-health issues.

The nature of decisions changed little when the board moved from advisory to policy making. New bylaws were adopted in 1980, to be consistent with the federal requirements and included the requirement that a quorum be a majority of members, not just those present. While membership continued high (2 0-24 members), attendance varied from 5 to 13, often without a quorum. Meetings were lengthy and included discussion of difficult issues, such as which patients bills should be sent to the collection agency, but frequently included no decisions. At other times, the decisions were related to organization of the Board, fundraising, or maintenance of membership. Politics and the Board

From the beginning, board members have been political activists and linkages have existed between board members with both political parties and with elected officials. Board members are or have been precinct committee persons and work at the polls on election days. The continued dominance of one political party in the city may have affected the demands that can be made by this community.

While meetings do not include explicit discussion of politics, political party loyalties occasionally create tensions on the board. When one board member invited Congressman Jacobs (Democrat) to a Board meeting,

dissatisfaction was expressed by other board members who were less than happy with the plan for his attendance at the meeting. However, the actual meeting went off without any problems. On another occasion, a member resigned from the board because he and the board president were running against each other in the primary election for a city-council position. Some Board members believed the departing member had joined the Board to increase his credibility in the neighborhood and garner support for his political campaign. Decision Making

A recurring issue with the Board is late or after-the-fact requests for approval of staff actions. As a part of HealthNet, the BHC Board must approve the contract with Methodist Hospital for clinical and administrative services. At one of these times, some board members believed that the Board should not sign the contract for Methodist Hospital to continue operation of the health center, because the contract was presented at the last minute without time for careful consideration. One board member, Tom Cole, was vehement in his objection to signing the contract. Rumors had been flying among the board members that another agency (of which Cole was director) wanted to take responsibility for the center. However, that agency was not a health or medical organization and the center would have had to be closed for some time in

order to make the transition. There was no guarantee that the federal government would be willing to fund the center if the change was made. This was a difficult decision for the Board members because it meant choosing between supporting a board member and keeping the center open. At one point, it seemed as if the Board was not going to sign the contract. A health center staff member suggested that a formal vote should be taken. Additional discussion followed and when the vote was called, the decision was made to sign the contract. The member from the other agency resigned on the spot and walked out of the meeting.

In the past two years, increased discussion has occurred related to decisions, with more questions asked about alternatives and how decisions will affect services. On issues where community members have strong feelings, staff are not always trusted to provide the necessary information and have occasionally been viewed as "the enemy". In one situation where an outreach worker popular with the community and board had been fired by his supervisor, Board meetings were moved away from the health center and held without staff in attendance. Agreement was eventually reached that the firing was justified, but the process used violated requirements of the organization's by-laws. Although ostensibly resolved, this issue is resurrected when other problems occur between Board and staff.

One of the problems created by having members who in some sense are representing other groups is that the other group's priorities may be given precedence over the health center's. In the continuing competition for funds, agency representatives sometimes attempt to take over successful projects started by the health center in order to continue operations or expand their own power base.

From the beginning the committee structure was intended to organize, discuss, and clarify issues before presentation to the board and this is becoming evident in meetings. Problems in decision making are not related to the amount of information available, but lie in understanding the information and the decisions to be made. In the past, although issues were discussed at length, the meeting might end without a formal vote being taken. The President then would make a decision outside of the meeting, based on her perception of the discussion. Members are sometimes reluctant to take a position on an issue. During some meetings when voice votes were taken, no dissension was expressed. However, close observation of the members disclosed that not all members voted on either side of the issue and did not formally abstain.

A former Board President believed it was the role of leadership to be certain that board members understand the issues before voting. This is an area she identified where additional discussion is needed to clarify and

inform.[8] The current President directs the discussion to ensure that issues are clear before votes are taken, and sometimes asks individual board members, in turn, what their opinions or concerns about the issue are.

Board decision making is affected by the manner in which information is transmitted throughout the neighborhood. Close linkages among some residents because of family relationships or long acquaintance have created a grapevine along which information "goes like wildfire" (Crenshaw). While this method gets information into the community very quickly, considerable distortion may occur and contribute to an unwillingness to listen to rational arguments on an issue. Charles Crenshaw, a board member reports he is often stopped by neighbors while he is taking his daily walk and must clarify misunderstandings of Board actions or health center policies.

Board members sometimes accept suggested decisions in the meetings and then voice dissatisfaction with the decision after the meeting. This is another area where persons in leadership positions must be sure board members understand the issues and encourage them to ask questions and express their own opinions. At some times (but not always) board membership has included persons who asked questions and provoked sufficient discussion to obtain opinions from a majority of the board members.

Members of the board have usually been involved in a number of organizations in the neighborhood and in the city in general. Because board members had such an extensive amount of involvement in organizations, it was assumed by the health center staff that the members would be prepared to take leadership roles in the health center board. However, the level of involvement (i.e., membership v. leadership) did not always prepare the members for leadership positions. For some individuals, leadership activities on the Board have helped them to develop a power base for activities outside the neighborhood, including positions on city-wide boards and election to political office.

In addition to facilitating understanding of decisions to be made, leaders are expected to guide new members through the first few years of board membership and encourage them to learn to work on committees and to carry out tasks. Some instruction is provided on general concepts related to board membership. Experienced board members are very accepting of the beginning board members and are supportive of their entry into board activities. Identifying persons with leadership skills who will accept leadership positions on the board is an ongoing problem. Although only one community resident was willing to serve as an officer in 1991, elections for 1992 brought a resurgence in interest from neighborhood residents.

CONTINUING COLLECTIVE ACTION

A perceived strength of the current board and the neighborhood is that "it will pull together when needed" (P.Hall) . This belief persists in spite of the fact that attempts to pursue community wide projects are not supported by the subgroups in the community. Although, this belief has not been tested in some time, it continues to be widely held.

Disagreements about how other services are to be provided in the neighborhood sometimes spill over into the BHC Board meetings. An example of such disagreements is the long running argument over whether CAAP or SEMSC should provide social services in the neighborhood. Each agency provides a power base for different segments of the community.

Services were provided in Clearstream Housing Project (in approximately 1981) by a satellite of the Southeast Multiservice Center (SEMSC) branch office operated by a past president of the Barrington Health Center Board, Barbara Cross. The Community Action Against Poverty (CAAP) Program had also expressed interest in serving the complexes. In the past, tenant council leaders have taken positions supporting either the SEMSC or CAAP and not attempted to obtain services from both organizations at the same time. When the organization supported by the leaders lacked the resources to provide social services in

167

the area, tenant council leadership has been unwilling to allow other organizations to provide services in the area.

In June 1990, social services were still not present in the neighborhood. Some Barrington Board members requested that CCI start a multiservice center in the area. CCI replied that the only way they could provide services in the area was through a satellite office out of SEMSC. While acceptable to Board members, former members and other community persons attended a Board meeting and expressed their anger at having a satellite rather than a full office. Councilman Strader was among the guests and was adamant that he did not want a satellite office of SEMSC in his district. He stated that he was negotiating with CAAP to provide a full service center in this area and that the health center board should stick to health matters. Two other guests also spoke forcefully against the satellite services. Health center board members were taken aback by the emotions accompanying the demands. Since the placement of a multiservice center in the area was not an action the Board could make, the members dropped the matter from discussion at Board meetings.

The need for social services in the area remained a concern of CCI and, although not discussed at meetings, of some board members. Nothing was heard from CAAP regarding starting services in the area. An employee of SEMSC began attending BHC Board meetings in the summer of 1991 and in

September announced that a satellite office had opened in the area. While no objections were raised, one board member (L. Morrison) commented that "you all know how I feel". The disagreement among board members and community residents over which agency should provide services continues. Although services are now provided in the area, it does not mean the disagreement will end.

In the past few years, the administrators of the housing complexes have provided institutional support for health and health related programs. Health center staff are welcomed in the complexes and space has been made available for well-child programs and youth programs. The complexes are represented on the Board by one of the persons who sat on the Board in 1978. No other board members have been recruited from the housing complexes.

The current membership of this board includes persons who were members of the health center advisory board started after Methodist assumed responsibility for BHC, as well as newer neighborhood persons and persons from outside the community. The Watoto-Wa-Simbas are no longer an active group in the community and only one (who does not live in the community) is a member of the board. One former Watoto member served several terms as a city councilman for the area. He maintained contact with board members and attempted to provide access to the wider political system for neighborhood persons.

The primary resource available in this community is the people. The may lack money and skills, but they identify access to a wide variety of elected and appointed officials as one of their major resources. Board members feel comfortable contacting Senators or Congressmen as well as local officials. One board member, Pamela Hall, had a contact person within the Regional office of DHHS who called her when discussions related to Barrington occurred at the regional office.

New members are usually recruited by word of mouth. A patient comment form is used at the center and patients sometimes respond positively to a question about interest in becoming a board member. Unfortunately, none of these positive responses have turned into actual members. The membership has varied between 12 and 25 persons. In 1991 there were 15 board members, 10 black and 5 white, with 3 black and 4 white members living outside the neighborhood.

Motivation

Recent board members describe themselves as partici-pating on the Board because of the tremendous needs in the neighborhood. Many people say they serve on the board because they want to help the neighborhood.

> "Volunteer work is, a person's
> got to really want to do it, see. And
> they ain't no rewards in it, other
> than the fact that you've had the
> satisfaction of knowing that you've
> helped to bring about certain things
> or correct things or alleviate some of
> the fears or answer some of the
> questions that people have. But
> volunteer help, you've got to want to
> do it. and you can't have a motive
> other than the fact that you want to
> help people". (C.Crenshaw)

Board members see the health center board as a mechanism for addressing a multitude of needs. Although community members may fight among themselves about a great many issues, most persons continue to see the health center as essential to the community. This view of the health center induces some people to join the board. One member recognized the importance of having a number of people as <u>active</u> participants and not working "one or two people to death".

One long time board member described her motivation as that of "love for people". This woman had a deep concern that health care be provided with dignity for those without any financial resources. She believes that staff and board members "don't hear the cry of the poor people" (Darby).

Some persons may participate on the board for the prestige involved. Although to an outsider little status may be associated with sitting on a health center board,

171

in this community it offers an opportunity for prestige to persons with no other claims to status. While no board members acknowledged this motivation for themselves, they did suggest that others may be participating for this reason.

Other Neighborhood Developments

In 1988, the city declared a portion of the neighborhood as a Housing Incentive Taxing Increment Financing (HOTIF) area. The BHC Board approved the HOTIF staff's use of a room at the center to interview potential participants as long as it did not interfere with activities of the WIC program, which also used the space. The HOTIF staff were there for only a few weeks and apparently did not initiate any projects with individuals.

A HOTIF project was initiated in the community by an outside developer. Without consulting residents as to their preferences for housing, the developer proposed remodeling deteriorated, unoccupied, and formerly subsidized units into one bedroom condominiums for local residents. While the cost of a unit was low, most potential buyers would have had to purchase two units and remodel to create sufficient space for their families. In addition, the condominium concept was not well accepted. When residents of this area consider home ownership, they picture a free standing house. The project has now failed financially and the model units prepared to generate sales

172

sit in disrepair, contributing to the desolation of the
area.

Board Members as Community Leaders

Community members turn to board members when they
have problems to be solved. Although the problems are
frequently outside the purview of the health center board,
the board member is perceived as someone who knows what to
do. Sometimes the only thing the board member can do is
direct the resident to the appropriate agency. In other
cases, complaints about unrelated services (e.g., police
response time) are brought to Health Center Board
meetings. In some instances where the board members
agree, a letter is sent or a phone call made in the name
of the Board.

SUMMARY

Barrington is an old neighborhood, and the residents
perceive (accurately) that they are neglected by the city.
The neighborhood contains a long established black
population that is distributed throughout the geographic
area, a block here and there within a larger white
community. The public housing complexes introduced
additional black residents from urban rather than rural
origins. However, they concur with other residents in
their lack of faith in organizations in the broader
community to fulfill promises. Physical elements

173

introduced by man serve to isolate various portions of the community, in terms of communication as well as spatially.

Barrington is a neighborhood with a weak institutional base. Although several industries are located in the area, they have not been involved in any community projects. St. Francis Hospital is in the adjacent area but not involved in Barrington activities. However, contact with St. Francis may have been limited because of the Methodist Hospital connection. Some commercial establishments are still in the area, but not a supermarket. The churches frequented by the black residents have been invited, but have not been willing to become active participants in addressing the social and welfare concerns present in the neighborhood.

Opportunities for interaction occur primarily within the churches and factions. The neighborhood is without a viable commercial area or central gathering places where people can interact on an informal basis. Bethel Park serves as a neutral gathering place for members of the black community, for example for the SouthSide reunion. The limited opportunities for interaction contribute to the maintenance of factions.

The action in Barrington was initiated by indigenous leaders, working without payment for their activities. Based on their experiences in other locations and their close relationship to the black segment of the Barrington

174

neighborhood, the leaders of the Watoto-Wa-Simbas, Strader
and Watts, recognized the needs of the neighborhood and
realized that organization was needed to address
neighborhood concerns. The Watoto-Wa-Simbas were an
exclusive rather than an inclusive organization, modeled
on the Black Panthers organization, and limited to black
males.

The leaders' previous experience and training
enhanced their leadership capacity and provided an
opportunity for mobilization that had not been available
previously in the neighborhood. Watts and Strader used
strategies learned in their work in other communities and
involved large numbers of neighborhood residents in
addition to those who belonged to the organization, thus
increasing the perception that the issues addressed were
common interests and not just those of the Watotos.

The neighborhood group in Barrington successfully
demanded that the health center be started in the
neighborhood by H & H, but was not involved in the actual
work of establishing and operating the health center,
coming later to that role after Methodist Hospital became
involved in this neighborhood. The initial decision may
reflect a realistic assessment of the group's resources
and abilities. Although the Watotos had received money
for a program aimed at reducing drug use among
neighborhood youth and were considered successful in that

project, health services were out of the realm of expertise of any of the members, and the group members lacked the linkages to appropriate resources.

The Watotos, as a militant black group, had the respect and support of the black segment of the Barrington community, and long term support — although weakly exhibited — for the health center. The group used a variety of tactics to enforce their demands, including sit-ins, mass attendance at meetings, and circling the City-County Building on their motorcycles. The militant roots of the BHC and the board, along with the myths of how the center was obtained, may have alienated the white residents of the neighborhood.

One of the shortcomings of the Watotos was their failure to provide continuing leadership after the health center was established by the health department. Rather than having a member or two sit on the advisory committee, the organization's leaders could have established the committee as part of their organizational structure, perhaps as a task force that allowed for membership from outside their organization.

When the federal government required that the centers have policy making community boards, this was a new role for board members, and one for which they had little preparation. They struggled with this change and have had difficulty obtaining the quorums necessary for official

decisions. Many residents are involved in political
activities in addition to the neighborhood factions and
bring political agendas to the board meetings. On some
occasions, open conflicts about political party issues
have occurred during board meetings.

This board has difficulty conceptualizing proposals
or funding requests when they must take the major
responsibility and has relied heavily on staff to initiate
ideas and proposals to which they respond. Some Board
members distrust the staff and frequently are dissatisfied
with staff proposals. Although Board members verbalize
their complaints, they appear reluctant to make
alternative proposals.

Among the members of the Board are some of the
original members of the board started by Methodist
Hospital staff. Although this violates the board's
bylaws, no one suggests that these members should not be
on the board. While such dedication is admirable, it
creates situations on the board where issues supposedly
resolved in the past are discussed again. In most cases,
no new decisions are made.

The BHC Board is still perceived as a general
community organization rather than a health center board.
Community members in general want the organization to
address general issues affecting the community such as
economic development, housing, and employment. Since

177

direct input into the operation of the health center is now the responsibility of HealthNet (including the representatives from the BHC board), the BHC board can apply its resources to these other issues.

A new group of neighborhood residents has become active on the BHC board, and in January 1992 a young black male neighborhood resident will become president of the board. He has the potential to be an excellent leader and has the backing of some neighborhood groups. Unknown at this time is whether or not his ties to a particular faction will limit his ability to move the organization forward into the new activities that are needed if the organization is to continue in existence.

Neighborhood residents report there being a strong sense of community. However, the evidence suggests a strong community exists only under special circumstances. These are discussed later in this chapter.

Obtaining information on the development of the Barrington Health center was problematic. The files of the Watoto-Wa-Simbas were destroyed in a fire some years ago. Fortunately, the organization was included by Rich (1976) in his study of neighborhood organizations in Indianapolis. Rich's information, combined with interviews and newspaper articles were the major sources of information for this chapter. Few of the members of the original advisory board established by the Watotos remain in the community and not all were willing to be interviewed.

While Jerry Watts (a former Watoto) confirmed the action in the mayor's office, other persons identified as participants in these activities would not confirm the events nor would they deny them. The myths continue and are given as examples of actions that can be taken if the community needs to apply pressure to local government.

The Health and Hospital Corporation is a municipal corporation and serves as the local health department for Marion County. It has two divisions, one which operates Wishard Hospital and the other which serves the public health function. As a municipal corporation, it is operated by a board appointed by the mayor of Indianapolis and the county commissioners.

Dates such as this one are rather tenuous. No records are available from 1972 to 1977 and different individuals sometimes give different reports. The 1974 date was selected as the closest approximation, since it would be congruent with other events occurring in the neighborhood.

6. During Fall 1977, I worked under a contract with the Health and Hospital Corporation to conduct a health needs assessment of the Barrington area and edit the final report for the assessment. One problem identified was that "Community leaders have little input regarding Barrington Health Center programs and policies". The recommendation made was to "Establish a community advisory committee for Barrington Health Center".

7. For a short time, Methodist Hospital served the administrative function for all neighborhood health centers in Indianapolis. That role reverted back to the Health and Hospital Corporation after a short time.

8. This is a touchy subject. One Board President expressed concern about Board members understanding of decisions and leadership's role in facilitating understanding. However, due to ill health she attended only one meeting of the nine meetings that have been held that year. Other leaders on the board have took over to the degree possible, but there was a lack of organizational skills among some of the board officers.

CHAPTER FIVE

COLLECTIVE ACTION ON THE NEAREASTSIDE

181

CHAPTER FIVE COLLECTIVE ACTION ON THE

NEAREASTSIDE

As in other inner city areas, in 1969 most physicians had
left the NearEastside, leaving behind a few elderly or
near retirement physicians. However, the NearEastside was
a neighborhood that had recently organized and was well
prepared to take advantage of the opportunities provided
by federal programs. People's Health Center on the Near-
Eastside was developed by a neighborhood organization
responsible for a number of Community Action Against
Poverty (CAAP) initiated projects.

Utilizing seed money from a private foundation, the
Health Committee of the Near East Side Community
Organization (NESCO) began to plan for health services in
the neighborhood. They first approached the hospitals in
the city to see if they were interested in providing
services in the neighborhood, but none were willing to
sponsor a clinic. The Health Committee then proceeded to
develop a free clinic which evolved into the People's
Health Center.

When the health center first began providing services
it was run with volunteer professional staff and
neighborhood volunteers as support staff. The health
center is now independent of the neighborhood
organization and is operated by a policy board with

members from both the neighborhood and the broader community. Qualified professionals and support staff operate the health center as an autonomous unit, not associated with any other institution.

The transition of this health service from free clinic to sophisticated health center was facilitated by integration of private and public money, local and federal policies that supported such ventures, and by community residents dedicated to improved conditions for themselves and their neighbors. To reach this advanced stage of development as an autonomous unit required creative use of resources, people as well as money.

NEIGHBORHOOD CONTEXT

The history of the NearEastside area goes back to the early days of the state of Indiana. Land in the area was first developed as farmland in 1819. After the move of the state capital to Indianapolis in 1825, Governor Noah Noble built a large home in the area on East Market Street. A few years later his son-in-law built a home on the current site of Highland Park. Further development of the area was somewhat limited until the purchase of land for an arsenal in 1862 to produce and store military equipment to be used against the Confederacy.

After the Civil War ended, residential development began to the east of the Arsenal. James Woodruff

purchased 77 acres which he developed into a park-like community for the wealthy of Indianapolis and large multi-storied homes graced the series of three parallel boulevards, each divided by esplanades. Woodruff Place was incorporated as a municipality in 1876. When Mr. Woodruff refused to allow an entrepreneur to build a grocery store in the area, the store was built to the west of Woodruff Place and the arsenal and a residential area grew up around the store. Houses were built in an area east of Woodruff Place for workmen in the brickyards that had been built in the area.

In the early 19 00s the arsenal was sold and became a part of the Indianapolis Public School system. Used first as a vocational school, it later became Arsenal Technical High School in the system. Some of the original buildings are still in use and the large campus associated with the high school is a focal point of many activities in the neighborhood.

Another governmental structure in the neighborhood is the Indiana State Women's Prison, built in 1876, several blocks to the east of Woodruff Place. This institution is still in the neighborhood, presenting a barbed wire and brick walled countenance to the neighboring residences.

The first residents of the area were primarily of German descent. When the Belt Railroad was being constructed in 1877, Irish workmen arrived in the

neighborhood and two large Catholic churches were built in the area, Holy Cross in 1886 and St. Philip Neri in 1909.

Accessibility to the center of the city encouraged residential development of the Near Eastside and by 193 0, 90 percent of the area had been developed (see Figure 5.1). The land use patterns in the neighborhood were established by 1940 and have been changed only to accommodate the introduction of interstate highways. All the services and shops needed for a comfortable life were available in the neighborhood.

The growth of the NearEastside was part of the growth of the city in general. The city of Indianapolis soon encircled the separate municipality of Woodruff Place and in 1961, Woodruff Place lost a long running and bitter battle with the city and was annexed as part of Indianapolis. Many residents left Woodruff Place and were part of a general exodus of middle class people from the area. For a time the sense of community in this area and the broader Near Eastside community was lost and many of the large residences were altered into multi-family apartment buildings. A general deterioration of the area followed. In more recent years, young professional families interested in inner city living have purchased some of the homes in Woodruff Place and returned them to single family status.
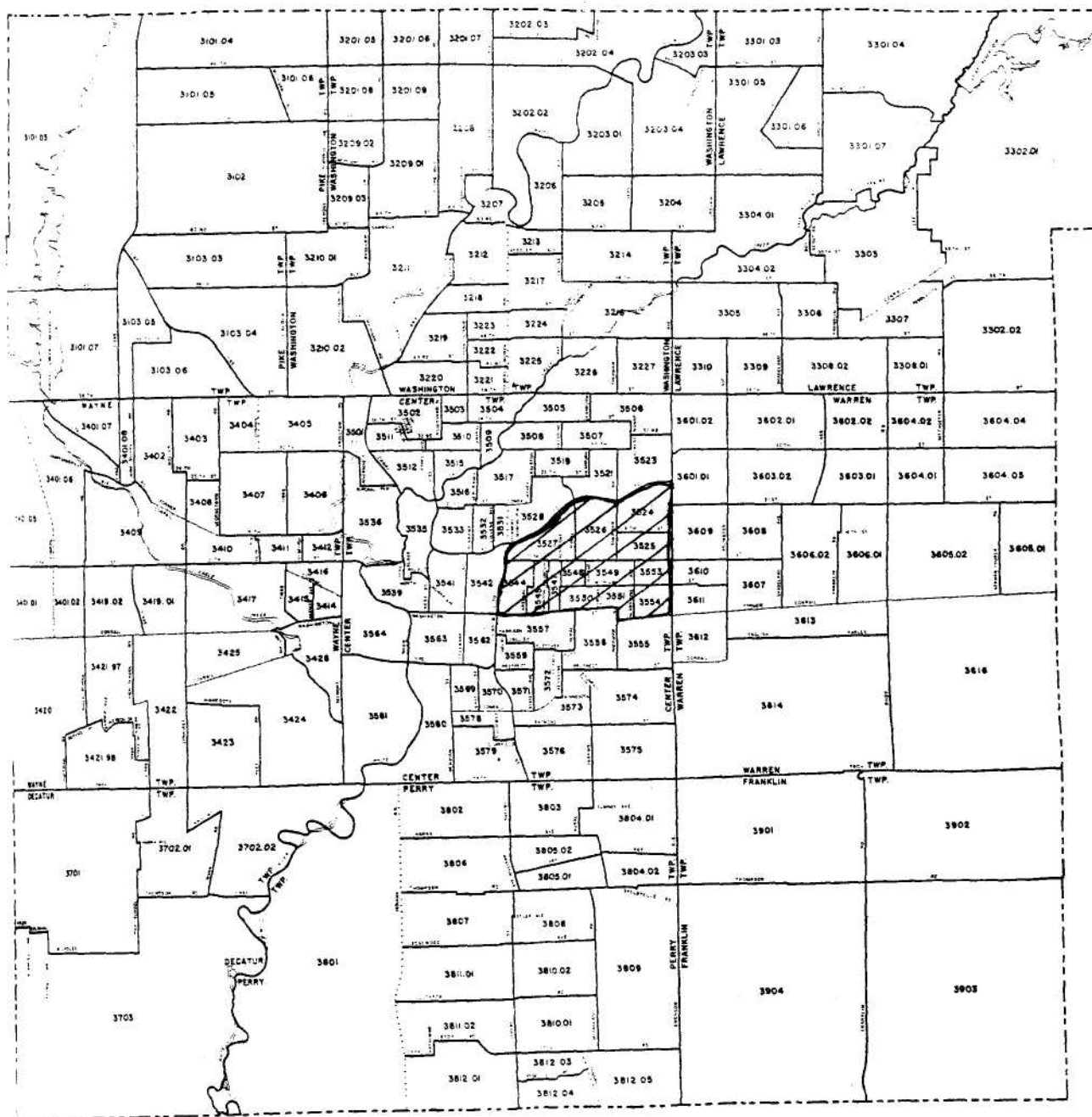
1990 CENSUS TRACTS

Figure 5,1.   NearEastside Neighborhood.

With the changing population characteristics came changes in the mix of services available in the neighborhood. Service providers and chain stores perceived the neighborhood as not providing a sufficient profit and began to leave the area, moving towards the edges of the city or to shopping centers. Small locally owned shops and convenience stores took their place. Most products were available for purchase in the area, but at a higher price. Although a Kroger store remains in the area, its prices are higher than in stores farther out from the center of the city. Replacement of the health care providers who left the area did not follow.

The changing demographics of the neighborhood have had both positive and negative effects. Recent changes in the neighborhood have provided a cadre of individuals with strong organizational skills and an interest in the health and stability of the community. However, value conflicts arise between the new and old residents around property upkeep, child rearing, and the appropriate use of public and private space. As one resident stated, she believed that cars should be parked on the street and not on the front lawn. <u>The NearEastside Today</u>

During the seventies, elevated interstate highways were built along the northern (I65)and western (I70)

187

perimeters of the neighborhood. The highways create

convoluted routes for local traffic, and limit entering or

leaving the neighborhood in those directions. The

neighborhood is bounded on the south by an east-west U.S.

highway (US-40) and cut by two parallel east-west one way

thoroughfares. The area immediately adjacent to the

highway contains many taverns and serves as a gathering

place for the homeless and prostitutes, both male and

female.   A major thoroughfare is to the east of the area

and contains additional commercial establishments. There

are some industries on the fringes of the area and

occasionally within the neighborhood. The main commercial

area is on Tenth Street, a major thoroughfare cutting

through the area from east to west. This area contains

most shops and services that are needed by residents

(including People's Health Center), as well as a

considerable number of used furniture and antique stores

and a more recent type of enterprise, furniture rental.

Mixed in with the retail enterprises are numerous bars.

The presence of the commercial area is important as large

numbers of residents do not own automobiles and rely on

local stores for necessities. Most of the housing in the

area was built more than 60 years ago and is in varying

states of repair. Many of the homes are quite large and

have gone through devolution into apartments and through

gentrification, back into single family homes. Woodruff

Place is considered a fashionable place for young professionals to live and the demographic characteristics of this small area are quite different from the rest of the neighborhood. Other sub-communities are also experiencing renovation of housing which brings in residents who are concerned about neighborhood improvement and property values. It is not unusual to see a house with major structural defects as well as peeling paint adjacent to a house that has been faithfully restored to its original condition.

One of the effects of the construction of highways and gentrification has been to reduce the number of housing units available in the area. However, some landlords continue to divide their buildings into additional units to meet the market demand for housing in the area, where the population density in the area is the highest in the city. People

The population of the neighborhood, as a whole, is predominantly white and about one fourth of the persons have Appalachian backgrounds. Many residents of the area have low incomes in contrast to some of the residents of Woodruff Place. The neighborhood is experiencing a decrease in total population while the black population is increasing, which has resulted in a dramatically higher increase in the percentage of blacks (see Table 5.1).

189

Table 5.1
Population Characteristics

	1960	1970	1980	1990
Total	54,651	51,141	45,802	42,953
% Black	1.5	4.4	4.5	10.9

Source: U.S. Census.

Although some homes are owned and occupied by long term residents, the population has a reputation for being highly mobile, moving frequently from house to house. However, most of the moves are made within the community. It is not unusual to see families moving their possessions in grocery carts or carrying larger furniture down the street from one apartment to the next. More than 50 percent of the families have lived on the Near Eastside for more than ten years, but the median length of time in their current home is three years (Ray and Selmanoff, 1985). As described by one board member, "The kids go down the block and say I've lived there, I've lived there, and I've lived there."

STARTING THE HEALTH CENTER

To understand the development of the People's Health Center, one must be aware of the organizational activity in the community that preceded the health center.

190

Development of NESCO

The Near Eastside Community Organization (NESCO) was
developed in 1969 with the assistance of federal funds
channeled through Marion County's Community Action Against
Poverty (CAAP) program. Although several small
organizations were in the neighborhood, no ongoing
community organization represented the community as a
collective unit. On the recommendation of James Kohls who
had been working with organizations on the south side,
Patricia Farrell a former nun trained in Alinsky-style
tactics was hired by CAAP to work in the Near Eastside and
develop a community organization.

Farrell contacted ministers of churches in the area
and persuaded them that it was in their interests to
participate in a community-wide organization. She
convinced the ministers that the churches and their
congregations would benefit from a neighborhood wide
organization and local ministers became the early leaders
in the group. After the churches were involved,
representatives from block clubs, senior citizens groups,
and labor unions were invited to participate in the
meetings. Although threatened by funding cuts for
organizing activities, NESCO grew quickly into a community
controlled organization with the power to make demands on
city government and obtain a positive response.

NESCO frequently took an adversarial position in relation to city government. City officials had been supportive of development of NESCO and saw the organization as one that could be counted on for approval of city plans for the area. Instead, the neighborhood people wanted more consideration of their input at earlier stages of the planning process. The organization's members were not content with mere approval of city-developed plans and intended to increase self governance in the community. Conflict situations with the city resulted in protest activities and in one case a lawsuit. The organization since has been recognized as a force to be contended with when decisions related to the community are made. <u>Demand for Health Care</u>

The NESCO board recognized that not all the services needed by the residents were available in the community. The continued economic deterioration was having an effect on the availability of health care services. Younger private physicians were moving on to areas that were more economically desirable, while the older ones struggled towards retirement. As the physicians ended their services in the community, the residents became increasingly concerned about where they would be able to get health care. The seriousness of the situation had been recognized by government agencies and the

192

Highland/Brookside neighborhood (the western part of the Near Eastside) had been designated as a federal medically under-served and health manpower shortage area. The 19 69 Department of Metropolitan Development Report on inner-city need areas in Indianapolis documented some of the health problems in the area - a high incidence of new tuberculosis cases, high infant mortality, and a large number of cases of venereal disease. Hospital and public health nursing clinics were distant and not easily accessible by public transportation. <u>NESCO Health Committee</u>

Once established as an advocate with city government for services in the community, NESCO members began to look at other ways to obtain services. The Irwin-Sweeney-Miller Foundation had given #38,000 to CAAP to support the NESCO administration. The NESCO board decided to use that money to fund development of a free health clinic by the Health Committee of NESCO. The foundation money served as seed money to develop health services on the Near Eastside and was administered through CAAP. Pat Farrell worked with the Health Committee to develop the concept of the clinic.

A chance phone call from a nurse who was pursuing a master's degree seeking to volunteer her services brought Toni Lawrie to the NearEastside. Lawrie was a former Peace Corps member and a Viet Nam veteran who had returned

to Indianapolis to pursue an advanced degree. She became bored with full time academic work and sought other activities to round out her life. Lawrie strongly believed in community empowerment and in making the system work for the people.

When Lawrie was interviewed by the Health Committee regarding volunteer work, she was asked to take a paying position and help start the clinic on the Near Eastside. She is a resourceful person who "beat the bushes" to find the personnel and supplies needed to start a clinic as well as providing the necessary technical knowledge needed for starting and running a health clinic.

A building was rented at 7 North Oriental Street and renovated to serve as a clinic. The Health Committee of NESCO met periodically to review the progress of the clinic and NESCO members provided assistance in the renovation. The early relationship of local churches to NESCO provided access to a suburban church and its more ample resources. The Second Presbyterian Church, located on the far north side of Indianapolis and served at that time by Rev. William Hudnut, provided the funds for the renovation of the building on Oriental Street.

The health clinic opened on April 12, 1971 in the Oriental Street building. The only paid personnel were Lawrie and the physicians. All other roles were filled by volunteers who were, for the most part, from the

neighborhood. Board members were active volunteers
filling most of the roles in the clinic, for example,
receptionist, measuring and weighing babies, taking
temperatures, and answering the phone. Non-board members
from the neighborhood also helped at the clinic. Many of
the people who were involved in helping with the clinic at
its first site have been described as "transients through
the area". The inexpensive small apartments throughout
the area attracted people whose lives were in transition.
Among these were veterans of the Viet Nam war who were
trying to sort out what to do with their lives. They were
very helpful with the renovation of the building. A school
for licensed practical nurses (LPNs) was located directly
behind the clinic and LPN students frequently volunteered
their services during clinic hours.

The physicians were "moonlighting" and their services
were available only in the evenings, so the clinic was
open only at those times. General sick call clinics were
held twice a week with additional afternoon programs
including Planned Parenthood services, immunizations and
eye clinics, and adult and juvenile group sessions
supervised by two volunteer psychologists.

Scarcity of resources affected the center's ability
to treat patients. Physicians in the city donated their
drug samples for use with patients unable to pay for

prescriptions. In some situations, the treatment depended on which drug was available for free. Other Organizational Activities

During the early years of the health center, the board members relied heavily on the community organizer and other staff to direct their actions. One staff member described them as "very pliable and needed direction." They were willing to take any action needed, but required assistance in determining priorities for the organization and in selecting the actions to achieve their goals.

It was not unusual for leaders to take busloads of people to the City-Council meetings when the hearings were related to neighborhood issues. Pat Farrell would, by hand signals, tell the people when to cheer and when to boo.

Pat Farrell and Toni Lawrie played their own version of the "skin game" described by the leaders in the Barrington area. Ms. Farrell would make the unreasonable requests and "rant and rave", followed by Ms. Lawrie who would offer to compromise and suggest a more moderate position. The tactic was successful and the desired ends achieved.

Neighborhood churches, their ministers and members, have always played an important role in community organization on the Near Eastside. During this initial period of the health center, local ministers played an

important role on the board of NESCO, serving in most leadership roles. Rev. William Quick, minister of a neighborhood United Church of Christ congregation in 1971 had been the first president of NESCO . In 1972 he left his church responsibilities and became director of People's Health Center. Other community ministers have been active on the board.

TRANSITION TO COMPREHENSIVE SERVICES

In 1972, $505,000 of Community Services Program funds through the Indianapolis City-Council was allotted to expand the clinic and to develop a full scale, community controlled health care service on the Near Eastside. To receive the funds, it was necessary to develop a separate organization independent of both NESCO and CAAP. The CAAP office agreed to act as the operating agency in an interim period of 4 months while the organization was developed. The link to CAAP during this time was crucial as it also provided some funds when a cash flow problem occurred.

Health Committee members of NESCO, with the assistance of Farrell and Lawrie developed "East Side Promise, Inc." (ESP), a not-for-profit corporation designed to put the community service money to work. According to the by-laws of this organization, NESCO officers were explicitly prohibited from being members of ESP to avoid any conflict of interest. Membership was

limited to representatives of organizations (see complete by-laws in Appendix). However, the small block clubs as well as large service agencies were included in the membership. The membership list as shown in the minutes contains individual names without mention of their organizational affiliation and includes residents who were patients as well as professionals working in agencies in the community. Although the organization had many members, it was operated by a small board of five persons. A New Organization

An autonomous health center was not the first choice of the new organization to obtain increased health care services in the community. ESP Board members first approached various local hospitals, including Methodist Hospital, and attempted to contract for provision of services in the community. Even with money available, local hospitals were not interested in providing health care services on the Near Eastside. John Murphy, former executive director of People's Health Center, described this retrospectively as "nobody wanted to mess with the east side". Since none of the local hospitals was interested in providing the community health services they desired, board members assumed the responsibility for developing an organization to provide the services.

Lawrie played a vital role in the development of the expanded services. She was responsible for planning the

services needed, working with health care professionals
and the architect, and developing a budget for the first
year.

Board members played a major role volunteering their
time to help in the renovation and the remodeling of a
former furniture store at 1621 East New York Street into a
professional health care facility. Plans to hire local
residents to do the remodeling were discarded because the
neighborhood people needed immediate payment for their
work. Many of the workmen who were hired worked part-time
or "after hours" workers and willing to wait for payment
until cash became available. However, the less than full-
time commitment of the workmen slowed the progress of the
work.

Every available source of labor was tapped. In
addition to local residents, Lawrie's family members, who
were carpenters and electricians, were pressed into
volunteering and providing guidance to other volunteers.
When health center staff were hired early in May 1972,
they spent their first few days of employment as semi-
skilled carpenters and completed the framing and paneling
of the examination rooms.

The new facility, known as People's Health Center
(PHC) , opened in late May 1972. During the initial stages
of operation of the center, the hospitals in the city were
approached for assistance in providing services. As many

of the patients were potentially clients of Wishard
Hospital, a referral system and a reciprocal relationship
to provide feedback to the health center was developed.
Other hospitals were less cooperative. When Community
Hospital was asked to provide access to free lab tests and
x-rays for poor patients, hospital administrators refused.
With the assistance of the Legal Services Organization
(LSO) , the health center board sued Community Hospital for
free services. This action prompted the hospital
administrator to reconsider his position and to admit that
acceptance of Hill-Burton funds had obligated them to
provide some free services to the poor. The end result
was that the free services were made available to poor
clients from People's Health Center.

Dedication of board members continued beyond the
physical activities related to renovation of the building.
Pat Dyson, a board member during this time (and later) was
a low income mother with several children. Even though
she was poor at the time, she felt very rich when the
health center opened. She would go to the center and
volunteer her time even though she had no skills, doing
whatever she could. She would even take money out of her
purse for people's medicine when they couldn't pay. Staff
described her as "our conscience".

Lawrie resigned after the health center moved to New
York Street to pursue other personal goals, although at

the request of the city she continued to provide
consultation to the Center. Under the direction of the
new administrator, Mr. William Quick, a staff of sixteen
people including three family practice residents,
affiliated with various community hospitals, began
providing free health care services for the 48,000 people
in the NESCO area. Expanded services were offered in many
areas. A four-chair dental office, three suites of
medical examining rooms, optometry facilities, laboratory,
and pharmacy allowed the staff to provide complete medical
care for all ages. Public Health Nursing staff, worked
side by side with center staff to provide integrated
services. Midtown Community Mental Health Center also
provided on-site programs for convenient referrals.

GROWTH OF THE HEALTH CENTER

At one time PHC was characterized as a "blue jean"
clinic because the physicians had an egalitarian
philosophy and believed that they should not be
distinguishable from the patients. Physicians dressed in
jeans and sneakers and provided care that was free. As
the cost of health care climbed sharply and the financial
support from government decreased, totally "free" health
care became a thing of the past. Charges for services
were instituted in 1975. With changes in physicians, the
staff took on a more professional appearance. PHC had

made the transition from a "free clinic" to a comprehensive health center providing a full range of services to patients based on their ability to pay. The reduction of local funding and the need to charge patients for a portion of their care resulted in the loss of pharmacy and optometry services.

Direct federal involvement with PHC began in 1975 with the placement of two National Health Service Corps (NHSC) physicians. In 1975, all the centers in the city experienced financial problems as funding was being shifted from the state and local level to the federal level. During this period People's Health Center staff sought and obtained NHSC doctors. Having these physicians allowed Peoples's to reduce their request for money from the city, thereby freeing that money for redistribution among the other health centers. Board members and the former administrator expressed concern that People's Health Center had never regained their fair share of city funds . However, in reviewing the city's report on the distribution of funds to neighborhood health centers in the city, People's appears to receive an amount proportional to their share of the total number of patients seen by health centers in the city.

Another NHSC physician was added to the practice in 1977 and the center was awarded substantial funding through the Department of Health and Human Services under

the Urban Health Initiatives Program. Provisions of this three year federal grant enabled PHC to purchase an existing warehouse structure at 2340 East 10th Street to be adapted to the Center's expanding needs.

The Federal Government has played an ongoing role in the financial history of the center. The staff have been active in pursuing federal grants for specific projects to meet needs in the neighborhood. People's Health Center began to receive Section 330 money in 1977. In 1978, the center was awarded a special grant that allowed expansion of services to adolescents. Later this money was included in the annual grant from DHHS. Other special federal grants have been obtained to pursue particular objectives. By 1979, the center budget was $7 00,000, with about $70,000 from patient revenue.

Renovation of the 10th Street building continued over a two year time period and in October 1980, the center moved to the current facility, which includes four suites of exam rooms, a dental department, pharmacy, and laboratory. The new facility was designed to provide easy access and patient flow since all services are available on one floor. Midtown Community Mental Health Center and the Division of Public Health still maintain space within the facility to provide services to their patients.

A licensed pharmacy was opened in 1981 along with the expansion of laboratory services to provide 90% of all

testing on-site. During 1981 the center was also awarded a three year accreditation by the Joint Commission on Accreditation of Hospitals (JCAH). People's Health Center maintains an emphasis on preventive care and utilizes a team approach that considers medical, dental and emotional needs of the population.

Board members continued to play an active role in decision making related to the health center and its programs. At one point a dentist who had been hired for the center was not performing as expected and the decision was made to fire him. The board handled it through the Personnel Committee, without involving the whole board. One of the members of the Personnel Committee had experience in a personnel department and provided the expertise needed by the committee. As a result of this incident, the board instituted quality assurance measures that would provide documentation of similar problems and make the committee's work easier. Although the Executive Director believed this was handled well by the committee, one board member during this time period described the experience of firing the dentist as "very painful".

Programs initiated by board members during this time included the "mothers and babies" program. Maureen McLean, a public health nurse and neighborhood resident, helped to set up the program and established linkages with local and suburban churches. The local church,

Westminster Presbyterian, provides the site for the
program, while Second Presbyterian, a suburban church,
provides some resources for the program. In the program
young mothers are taught parenting skills, assisted in
working out personal problems, and encouraged in their
pursuit of education and employment. This program is well
received by the young women and continues in operation.

McLean also initiated a "mentor mother" program, in
which young mothers are matched with an experienced mother
who can serve as a role model and provide guidance. This
program has been duplicated in other areas and is
considered very successful.

A consumer board member, Pat King, was a member of
the Patient Services Committee. She suggested that a play
area be established for children to be used while their
parents were in the doctor's office. The committee took
on the project and an area was blocked off away from other
patients and stocked with toys and games.

Staff also suggested new or expanded programs which,
if approved by the board, were implemented. Chris Guba,
the dentist, was concerned because no walk-in dental
service was available and requested that the board approve
expansion of the dental services. The board agreed and a
walk-in dental program was added.

Membership and Motivation

The People's Health Center Board has 25 members. Consistent with the DHHS guidelines for health centers receiving 330 monies, 13 members are consumers and the other 12 are persons with skills needed to create a board that is competent to address issues that arise. Considerable efforts are made to identify and recruit persons with particular skills for the nonconsumer members positions. People seem to look on membership as a privilege and seldom refuse to serve. The board frequently has representatives from law, accounting, personnel relations, and business. The former director of the Model Cities Program (and current vice president of Methodist Hospital) served on the Board. He was recruited to the Board as a friend of a staff member. The Nominations Committee has recently recruited a new member with expertise in public relations. Having a well balanced board, with different backgrounds and broad variety, makes this a strong board. Board leaders recognize the need to find activities or "projects" for new board members so that their interest level is maintained. Board leaders make many phone calls to board members to suggest committees or projects that need additional board attention. By maintaining active par-

ticipation of the members, the feeling of "rubber stamping" decisions is avoided.

The by-laws of the organization limit board members to two 3-year terms. Not all members leave at the same time so there is continuity on the board. A benefit of this system has been to increase the number of people in the community who are aware of and concerned about the People's Health Center. New members arrive with a fresh viewpoint and new ideas. Rotation of members avoids the problems of entrenchment in which a member may begin to have such a personal investment in Board activities that he takes personally any decision made by the Board. The presence of interested and qualified potential board members in the neighborhood is a great asset.

Before starting to recruit new members, the board considers the expertise needed on the board and explicitly recruits persons with that expertise. Nonconsumer board members are most often identified and recommended on the basis on personal knowledge of existing board members. It is believed that this allows selection of individuals who will make a contribution to the board and not just be "bodies" on the board. Consumer board members are recommended by health center staff or by other board members to the Executive Director, who passes the information on to the Nominating Committee.

New members are asked to make a commitment for a
three year time period. Recruitment of these members
includes meeting with the Executive Director to discuss
the role of the board member and, sometimes, going to
lunch in a neighborhood establishment (patronized by the
local folk) with some of the current board members. The
venture into the local environment helps to test the
potential member's acceptance of the neighborhood culture.

At different times there have been some efforts to
smooth the transition from outsider to board member. As
part of the new member orientation, members are given a
brief description of the history of the health center, a
glossary of terms (to help the new board member through
the federal alphabet soup), and an organizational chart. A
sketchy description of the origins of the health center is
also given.

A benefit of board membership is the occasional
opportunity for members to attend national meetings at
Board expense. Members are also sent to local educational
meetings. Many of the board members believe they gain new
knowledge from board membership, ranging from knowledge
about health center programs available to additional
expertise in administration or finance.

The active board members spend a considerable amount
of time on board activities. One former board president
reported spending 4 to 5 hours per week in addition to the

meetings attended. Her usual time involvement was about
10 hours per month. The reasons for this high level of
commitment among the members of the health center board
are varied. Many board members view involvement with the
People's Health Center Board as rewarding because "it's
the kind of institution where you can see that it makes a
difference in people's lives."

Reasons for agreeing to participate in health center
activities are diverse. The health center board members
have a genuine concern about the people of the
neighborhood and their need for health services. Some
members have a commitment to community-based
organizations, and the health center board is the current
focus of that commitment. One board member, Barbara
Black, had been involved in community-based organization
since she was 16, and felt that this was what she "was
good at doing". Although board members may have served on
other boards, the Peoples' Health Center Board is usually
their first experience in the health care field.

Several health center board members expressed a
philosophy that health care was a right of all people, and
saw People's Health Center as the way to fulfill society's
obligation for the health of the residents of the Near
Eastside. The general failure of governments to provide
health care for all sectors was characterized as
appalling. Other members focus on the importance of

health care in people's lives and their commitment is to
ensuring that health care continues to be provided in the
community and accessible to persons at all economic levels.

Board members who are neighborhood residents,
consumers and non-consumers alike, share an interest in
bettering the community in which they live. Participation
on the health center board is seen as one way in which
they contribute to neighborhood improvement, giving them
"a feeling of belonging to a community."

In talking with members of the board it is clear that
consumers and non-consumers sometimes have different,
although not necessarily contradictory, concerns. Each
group has a high degree of respect for the other,
recognizing that the different perspective brought by the
two groups are necessary for successful operation of the
center.

For consumer board members, membership on the board
tends to be their first board involvement and they are
pleased to be asked to be on the board. They perceive a
certain amount of status in board membership and the
opportunity to mix with professionals from a wide variety
of fields.   Consumers are committed to the board because
of what the center means to them and their families as
well as to the community. They share a commitment to
making the health center "a better place to go." Consumer

board members are more likely to serve on the Patient Services Committee and to express less understanding of the other issues (especially financial) addressed by the board.

Consumer board members participate on the board in order to help others. They feel that they have input into the operation of the center and that their suggestions are taken seriously. Cindy Dillahay, consumer member and former board president, believes that board participation provided her and other consumer members with information about "what's going on in your community," which they share with other neighborhood folk.

The Board functions as a strong support system for personal growth of its members. Former consumer board members were eloquent in the description of their personal gains from being a board member. Without exception, they perceived extensive personal growth as a result of their participation. One woman described herself as going from an introvert to a person who could stand up and speak at meetings and now takes leadership roles in other organizations. For another woman, the health center provided major dental work which dramatically altered her physical appearance, while health center staff and the board provided guidance for her in completing her GED and additional training which led to employment. While on the board, she had made a suggestion about the facility which

211

had been accepted and made the services more accessible for women with children. She felt that her input was valued by the board and that she had played an important role there.

Many of the nonconsumer board members live in the Near Eastside neighborhood. The gentrification that has pushed some low income residents out of the neighborhood has brought to the neighborhood individuals who are concerned about the conditions that affect their less affluent neighbors. These "new" residents are a valuable resource to the community as they combine knowledge of the community with the expertise needed by the Board to continue operation of the health center. These members also share resources that accrue to them because of their position in the business world. For example, one board member who is an accountant assigned one of his younger staff members to assist the health center with an audit.

All of the non-consumers expressed belief in the concept of a neighborhood health center, believe People's is a well-run quality organization, and want to be affiliated with it. However, status does not seem to be a consideration for this group of board members. Within the metropolitan area, membership on a health center board does not carry the prestige associated with involvement in city wide organizations such as the United Way.

Among the young female members of the board who are
neighborhood residents and come from upper middle class
backgrounds, membership is a continuation of the tradition
of volunteer service presented by older female members of
their families. As one board member described her
situation, there was "a tradition of community orientation
that I had at home. This is what I can do."   Membership
also offers an opportunity for these women to participate
in adult activities that are not child centered. Some
members also perceive a debt to society, as described by
Debbie Hedges: "So now I can perceive it, if not mission,
at least what I owe society." <u>Linkages to the Broader</u>
<u>Community</u>

As the health center increased in size (both number
of patients and dollars), additional relationships were
developed with local hospitals. Wishard Hospital accepted
the National Health Service Corps physicians on their
staff and they were given admitting privileges. Of the
local hospitals, Wishard was the most cordial to the
health center. In later years, admitting privileges were
gained at Methodist hospital.

The health center has a long history of linkages to
other health related services in the city. From the first
days of the center on Oriental Avenue the Marion County
Health Department, through the Division of Public Health
Nursing, provided well child services in the center on

selected days. Attempts to integrate the Health
Department services more fully with the health center
services have failed for lack of support from health
department administrators.

A strong spirit of cooperation exists among the
various agencies located in the Near Eastside community.
Evidence of this is shown in the cooperative provision of
services and in the encouragement of employees to serve on
the boards of other agencies by allowing this involvement
during working hours. Other community-based organizations
in the neighborhood include a multiservice center, a
credit union, and an economic development organization.

Provoked by DHHS interest in dealing with only one
organization in Indianapolis, discussions were held
regarding merger of People's Health Center and HealthNet.
Issues related to territory, power, and control surfaced
and little progress was made toward a merger. Murphy
believed that the issue of control was the primary
deterrent to merger, with the three individual local
boards affiliated with HealthNet fearing loss of control
of their centers. Murphy was not convinced that merger
would have a positive effect on patient care and, indeed,
might have a negative impact because so much time would
have to be devoted to restructuring the administrative
systems. When federal interest waned, he let the issue
drop. However, some PHC board members occasionally raise

the issue, and if federal interest in simplifying their work is renewed the merger issue will be addressed again.

Political Connections

When the health services were being developed in the neighborhood, the health committee and staff had frequent confrontations with the political system to obtain needed resources. The interactions with the political system continued into the early days of the operation of the center on New York Street. Now that the center is well established and resources obtained, few contacts are made with elected governmental officials, and contact with the city bureaucracy is primarily with the office which distributes funds. None of the recent board members could recall initiating contact with a city-county council member or state legislator and many of them do not know the names of these community representatives. Contacts with congressional members are made as part of participation in a national meeting.   The lack of local political involvement is in sharp contrast to the high level of political activity of other organizations in this neighborhood. The board president (Hedges) characterized the organization as apolitical, and was concerned that the lack of political involvement reduced their information level about activities being initiated by the city. Several board members were concerned that the center's apolitical nature has resulted in lack of

recognition by city government of the center's contribution to the community.

Leaders

When current board members were asked to identify leaders on the board, the persons identified were all nonconsumer board members. Historically consumers have been in leadership positions, but among present members were rarely referenced when questions were asked about leadership in the organization.

The Gabriel Richard leadership development course has been offered on the Near Eastside for several years. However, the persons completing these courses have not shown up on the People's Board. Murphy expressed his concern about leadership development in the neighborhood: "The one thing that was always frustrating to me is that all this leadership training has been going on for two or three years and we still weren't getting those people on our board. I'm not real sure where these people were ending up or who they were going to." It is not clear if the persons completing the course are taking leadership roles in other organizations or are simply not putting their new knowledge to work. Board members identify inadequate leadership skills among the neighborhood folk as a continuing problem.

Members of the Executive Committee are a part of the cadre of leaders of the People's board, including the

officers of the Board. The Executive Committee reviews
issues being considered for inclusion in the agenda for
meetings of the full board and makes decisions about what
the full board needs to know. One board officer expressed
concern that the Executive Committee was too paternalistic
in its approach to the full board. The perception among
some members is that disagreements are resolved in the
Executive Committee meetings, and full information is not
given to the full board. Instead, decisions are presented
for approval. Board President Hedges saw the Executive
Committee as doing most of the work, saying "..if you're a
board member, if you're not on the executive committee,
you don't have much to do." Committee Structure

The committee process is seen by PHC Board members as
the key to a board that feels they are important in the
operation of the center. Committees do much of the "nuts
and bolts" work of the board. Most issues will have been
reviewed by at least one committee and a recommendation
for action made by the committee. However, considerable
debate may still occur when the issue is presented to the
full board.

Committees and subcommittees allow opportunities for
all the board members to be actively involved in some
aspect of the decision making and problem solving. It is
believed that the people are more likely to be active and

217

to speak up in a group of three or four persons whom they have learned to know than in the larger group. Although members generally volunteer for committees, some committee members are appointed based on their particular expertise and the organization's needs.

Committees also provide an educational function, facilitating board member understanding of the issues. Board leaders use the committees as a testing ground for new members' commitment to an active role on the board. When committee members fulfill their roles on committees they are considered for additional Board responsibilities.

Conflicts have occurred over the role of staff on committees. One committee chairperson, a consumer member, felt that the staff person assigned to the committee had taken over the control of the committee. The staff person insisted that if he could not be present the committee meeting could not be held. Although frustrated by the situation and not agreeing with the staff position, the chairperson conceded and did not hold the meetings without the staff person.

Recently, the development of task forces has been proposed. These groups may focus on physical improvement of the building housing the center. Projects proposed include grounds beautification and building maintenance. Such projects provide an opportunity for members who have

skills in these areas and are less comfortable with the
activities of the committees.

The world view shared by the current director and
board president differs somewhat from those of previous
holders of these positions. "There's no reason the place
can't be run like a business and still have mission. You
can collect..." The belief is that the center should rely
more on the revenues generated by its services or other
locally generated funds and reduce reliance on federal or
local government funding. Evidence of movement towards
this goal is shown in the renaming of the former "patient
advocate" position as the "patient accounts manager".
Insufficient time has passed to determine if the
philosophy of accessibility for the poor has changed. In
terms of quality of operation, People's Health Center is
considered by the federal government to be in the upper
twenty five percent of all health centers in the country.
The current staff of thirty-four individuals maintains an
emphasis on preventive care and utilizes a team approach
that considers medical, dental and emotional needs of the
population. Staff are praised by patients as being
friendly and interested in patients as individuals.

Decision Making and Control

Board members perceive themselves as being in control
of the decision making for the health center and express
strong feelings about this issue:

"The People's Health Center Board is the one
community health center that does have control, I
mean we have the ultimate say" (McLean) "There is a
lot of ownership and pride on the board's part at
People's. People's board does focus on the mission,
it's really concerned that mission is carried out".
(Black)

The PHC Board is structured to be a policy making
board and is perceived that way by Board members. One
former President of the board expressed considerable
satisfaction with the policy focus, as it allowed the
board to focus on philosophical and directional issues and
not to be side-tracked by operational issues. Neighborhood
residents who have not been involved in the governance of
the health center do not understand well the structure and
functions of the board. In a survey of neighborhood
residents in 1985, a majority reported that the health
center was not responsive to neighborhood needs and that
they were unable to influence the center's activities (Ray
and Selmanoff, 1985).

Board decisions cover a variety of topics. A current
and recurring issue is the view of patient fees and the
nature of the fee structure. Strategic planning was an
area in which Debbie Hedges, board president, perceived
the board as working extremely well. However, she
admitted to difficulty in involving all board members in

the philosophical issues related to planning for the future. Many board members were not comfortable with policy issues, but would respond to other activities such as garage sales to raise funds for the center or maintenance of the building.

Issues are brought to the Board related to the development of policy, while staff focus on procedures to implement the policies. The Board routinely approve grants, budgets, and financial statements. From a former Director's point of view, the Board made decisions about the big issues, such as initiating new programs and implementing a new personnel policy. His role was to work. with the board. Board members confirm the policy making nature of the board. As one stated, "It was totally policy making, we made all the policy." When compared to other boards in the community, People's board members see the health center board as making more policy decisions.

One Board member described the People's Health Center as having "more community ownership" than other health centers in the city, with the final say in all important decisions. The centers operated by HealthNet were considered by this person to be "owned by the (Methodist) hospital".

While some members believed the Executive Committee conducted the major discussion of issues, other members perceived the discussions occurring during the board

meetings as guiding the decisions. A former member described major issues as being thoroughly discussed in the meetings: "we talked about it and made it more sensible so all board members could understand it." On the other hand, concern exists that use of terms such as "revenue enhancement" is confusing to consumer board members and greater efforts are needed to maintain an environment that is conducive to full participation by all board members. Active participation in the discussion of issues and the expression of divergent views are highly valued.

Information comes primarily from the Executive Director and the network of agency directors and staff within the neighborhood. The staff are perceived as doing an excellent job of explaining issues and have been "very frank" in presenting issues. Current staff members are commended by the board members for explaining things to the board in language that is understandable to them in a non-condescending manner. In addition, the board has benefited from the professional expertise of nonconsumer members. A few of the board members are characterized as "aggressive" and ask questions until they are satisfied that they and other board members understand the issue. The consumer board members tend to participate less in the board meetings and appear to be somewhat intimidated. A consumer board member reported that consumers tend to

think that "everybody else has all the answers and every-
thing's fine and that's what they should do. But, they're
[the consumers] not in on the discussion..."

For the most part the decisions made are seen as
routine and fairly uninteresting. On some occasions
issues arise that engage the board more completely. An
example given of such an issue was the nature of the care
to be given to a dental patient. The conflict arose
because the patient preferred a procedure that was more
expensive than had originally been planned. The issue
worked its way through the appropriate committees and
eventually was presented to the full board.

Murphy, former Executive Director, believed that the
Board gave the director a high level of autonomy. As
Director, he would assemble information about the
direction in which he thought the health center should be
headed and present it to the board. If members were
having trouble understanding an issue he would explain it
as many times as was necessary to be sure board members
understood the decision facing them. Murphy believes that
the nearly unanimous Board approval of his ideas was the
result of being "on the same wave length" and of good
communication. Board actions were not perceived by Murphy
or the board members as a "rubber stamp" of his ideas.
Members felt there was mutual respect between Murphy and

the board, which facilitated decision making and operation of the health center.

The Board can also be involved with the funding and regulatory agencies. The Executive Committee of the Board initiated contact with the Director of Region V DHHS office when the health center Executive Director was unable to give adequate explanations of the federal agency representative's actions. Debbie Hedges described this as "We like to act, in situations where it would not be good politics for the director to act". As the request for information came from the Board, the committee was able to pursue questions that the health center director had been unable to get answered by the regional office staff assigned to work with People's. Executive Committee members take delight in telling of writing the letter. Although no response to the letter was ever received, the Director received feedback from the Regional Office that they were unhappy about receiving the letter. While supportive of community control on the one hand, the federal officials have an underlying expectation that the executive director will restrict the actions of the board.

The financial condition of the health center is carefully reviewed at board meetings and board approval of grant budgets is required. Operational decisions such as the sliding fee scale and the health center hours are made by the board.

Dependence on the federal government for federal funds creates a strain on the staff. Federal irrationality, demanding one thing in one fiscal year and the opposite in the next year frustrates long term planning and a feeling of accomplishing goals. In 1985, requests for a slight increase in funds for additional physicians and facility modifications were denied because the city was not designated as a high need area. At the same time other centers in the country were being required to increase the number of physicians at their centers. In one of these centers, physicians frustrated because there was not enough for them to do left the centers for practices they considered more challenging.

Two years later, Indianapolis was nationally known for having the highest black infant mortality in a city greater than 500,000. DHHS Region V officials then wanted to allot large sums of money to address the problem, whereas a positive response to earlier requests for money might have helped to reduce the high infant mortality rate.

Murphy was frustrated by the government irrationality and decided "I couldn't do this any more for my sanity, I couldn't just brush this stuff off. And when you see that kind of irrational behavior, and you see the long term effects. We all ask for such a small amount of money". Murphy resigned the position of director that he had held

for 10 years and entered the private sector as a manager

director challenged the board to fulfill its
responsibility. The bylaws state that the board is
responsible for hiring the director. Because Murphy had
been in the position for such a long time, no one on the
board had experience in the process required. Murphy
described the experience as testing the board and showing
the strength they had. Staff expressed discontent with
the process being the responsibility of the board. Murphy
facilitated the transition, helping staff to understand
that they could participate in the search and screen
process, but the final decision rested with the board and
they could hire whomever they wanted, and "there's nothing
staff could do about it".

The search and screen process made heavy demands on
committee members. Diane Pfieffer, a board member and a
staff member at NEMSC, was a member of the search and
screen committee. She estimated that she spent 45 hours
over a six week period in that activity in addition to her
usual Board commitment. John Boner, the director of NEMSC
is supportive of Pfieffer's participation on the PHC
board, and part of her board activities occur during work
hours. Boner believes her role on the board provides an

226

information link between the two agencies and is
beneficial for both agencies.

SUMMARY

Outside activists were brought into the NearEastside
area with funding from CAAP and other external agencies
and collaborated with local ministers and the members of
their congregations in starting NESCO, which later started
the health center. The outside activists saw themselves
as temporary leaders and worked to ensure persons would be
available to take leadership positions after they went on
to other work. Neighborhood residents were conceptualized
in the short run as a critical mass, waiting for a leader
and needing guidance and assistance in pursuit of the
collective good.

The professional staff provided essential leadership
without which a health center would not have been started.
While the center board meets federal requirements for
consumer involvement, consumers continue to be followers
rather than leaders in this organization. However, the
wide experience of neighborhood folk in community
organizations has generated a wisdom among them not seen
in other neighborhoods.

Board members express high levels of commitment to
the Board and the center and spend many hours per month on
Board activities. The strength of this board is reflected

in its ability to deal with turnover in directors and the response required to hire another new director.

Linkages to resources in the broader community have supported a wide variety of grassroots based actions in the neighborhood. External resources have provided support in general and funding for projects. Churches in the area are attended primarily by local residents and include mainstream denominations as well as storefronts. The Westminster Presbyterian church has served as a link to suburban churches that have provided money for NearEastside projects. A local bank branch provides another link to the broader community and has served as a source of board members.

The population of this neighborhood has been expanded by gentrification to include young professionals as well as the original low income residents, with the potential for value conflicts. The low income residents are primarily of Appalachian background and among the poorest people in the county, but have developed the skills needed to participate in and maintain neighborhood organizations. Residents move frequently within the neighborhood, staying within the neighborhood because of the services available there.

Currently the leadership comes primarily from the nonconsumer members of the board. Gentrification of the area by persons with experience as leaders and a high

level of social concerns has made a major contribution to leadership on the PHC board. Although not always in the formal leadership positions, they provide strong support for consumer leaders.

The multiplicity of social service organizations supports collective action on the NearEastside by allowing their employees to participate in the PHC Board as part of their work. The wide variety of housing available in the neighborhood has contributed to the decision of some agency workers to reside in the area.

Leadership by outside professionals provided the necessary impetus for the project. Outside funding supported the professional staff, who used Alinsky type tactics: disruption, skin games, and masses of neighborhood people. The strength of NESCO was established prior to developing the health services. The adversarial tactics used to win conflicts with the city were used with hospitals to gain necessary cooperation.

Neighborhood folk were a major resource in establishing the health services. They volunteered for diverse tasks from taking temperatures to building walls. Staff also assisted in construction activities.

Current board members at Peoples Health Center have little sense of the process by which the health center was developed and funded or of the major funding crises that have occurred during its history; that is, little

229

institutional memory exists at People's in contrast to the other health centers. However, this may be a positive feature as they are less restricted by the past. While PHC board members have less sense of history of the center, they may have more sense of the present. Introduction of new members into the board at PHC brings new ideas and increases the level of ownership of the center in the neighborhood.

The executive director has played a major leadership role for the board as well as in the provision of services. Past and former members were consistent in their praise of the executive directors and their willingness to provide information needed for decisions. Uncertainty about whether staff were leaders or members of board committees has created some problems and may reflect consumer members' confrontations with professional dominance. The expression of divergent views is valued by members of the PHC board. This board seems more accepting of varied opinions than the other two boards.

The organization was created to deliver services and the board has always been the major actor in decision making. Board members see themselves as the policy makers. Mutual respect exists between the executive director and board members. The board makes decisions about hiring, firing, building renovation and maintenance,

fees, and patient grievances. No nontechnical decisions are outside the purview of this board.

The NESCO organization was and continues to be active in lobbying local officials. However, the PHC Board can best be described as apolitical, initiating no contact on behalf of the organization.   The result is a perceived lack of information about what is going on in the city that may affect the health center.

The PHC board is attentive to its bylaws and members serve limited terms of office. In the neighborhood now are a number of people who have at one time or another been members of the PHC board, creating a sense of community ownership of the health center and a belief in the power of neighborhood people to influence the organization.

Although the specific motivations described were diverse, they can be categorized as purposive. The initial motivation was the desperate need for accessible health services and a belief that by working together neighborhood residents could obtain the services. Consumer members express concerns similar to those expressed by the original group. They want to "better the community" and make the health center a "better place to go" for other as well as themselves. Consumer members also value the access to information provided at the health center board meetings and see their role as

learning about things and taking the information to others
in the community.

The participation of some nonconsumer board members
is supported by their employers and viewed as part of
their job. Nonconsumer members were more philosophical in
presenting their motivation. In addition to a genuine
concern about their neighbors, they view health care as a
right. The commitment of some nonconsumer members to
community-based organizations helps ensure that board
members less skilled in working with organizations will
have an opportunity to participate fully. Board
membership continue a tradition of voluntary service for
some nonconsumer board members.

Throughout the years the future of the center has
been challenged by changes in the philosophy of health
care delivery and financing. The health center board, by
being able to meet these challenges successfully, has
fostered an attitude of confidence and achievement in the
development of a quality health care program for the Near
Eastside neighborhood.

CHAPTER SIX

LOW RESOURCE NEIGHBORHOODS: CREATING CAPITAL

CHAPTER SIX LOW RESOURCE

NEIGHBORHOODS: CREATING CAPITAL

In the last three chapters, historic case studies of three
neighborhood health centers in Indianapolis have been
presented. The neighborhoods are notable for their
physical deterioration and lack of monetary resources.
Each of the neighborhoods had earlier experienced a loss
of health care services due to the departure of private
physicians.

Much of the need and the resulting demand for health
services are not governed by choice but by factors out of
the control of the individual. Since individuals do not
know when they will need the services, it is in their
interest to work with others to ensure that services are
available when needed, reducing the predicted tension
between interests of the individual and the group (Olson,
1965).

In each neighborhood, residents sought a collective
solution, a health center in the neighborhood that would
provide primary health care. Although each neighborhood
group started from a different base and obtained resources
in a distinct manner, the results have been the same, an

ongoing service that attempts to meet the needs of the people.

As noted in Chapter Two, resource mobilization theory emphasizes the importance of structural factors, such as the availability of resources and the position of individuals in social networks and the rationality of participation (Jenkins, 1983). Groups with limited resources must rely more on external sources for material resources needed to reach their goals. Groups of persons who saw themselves as excluded from decision making and needed resources, organized to make demands on others (Jenkins,1983). An entrepreneurial model of leadership in which the focus is on acquisition of resources is most relevant for these groups.

Olson's theory is inadequate in explaining collective action in low resource neighborhoods. However, modifying the theory with elements from resource mobilization theory fills in the gaps. Consistent with the resource mobilization approach, entrepreneurs, either neighborhood people as in the Barrington case or activists brought in from the outside (as in the NearEastside and SouthEastside), provided the necessary leadership to develop organizations and linked the neighborhoods organizations and the resources. Free riding (as described by Olson) or nonparticipation was a minimal problem in the three neighborhoods studied. A critical

mass of people is essential for collective action in low resource neighborhoods. The experience of neighborhood folk in attempting to work with local government on an individual basis and their lack of success provided compelling reasons for individuals to participate. Neighborhood residents recognized their powerlessness as individuals and were aware of collective action by other groups in similar situations. Members of the other groups were forming organizations and taking control of some of the institutions that affected their lives. Unlike most social movements, the neighborhood health center organizations were not _against_ some issue, but successfully pursued a collective good that was valued highly.

Earlier pessimistic theories suggest such action will not occur, based on extreme assumptions of economic rationality. If we treat people as caught in this inexorable tragedy of being unable to help themselves, the next step is to think we must take control and do things _for_ them. These actions lead to an antidemocratic set of policies and, in the case of health centers, moves away from democratic control.

However, the work of Henig and others point to the possibility of collective action occurring in low resource neighborhoods. The model is not a deterministic view of the world, but a view of factors and events that make it

possible for mobilization to occur. When people have
certain resources, they can do this.

In my estimation, the best way to understand the
collective action related to health centers in a way that
is illuminating for my study is a modification of Henig's
factors as shown in Table 6.1. The content in some cells
has been modified to include action for health centers
rather than action against redevelopment. The dynamic and
immediate nature of the neighborhood events (situational
factors) make them the most visible, but they are impacted
by parameters that extraneighborhood and contextual
factors define. In trying to understand collective action
in neighborhoods, factors in all four cells must be
considered.

This final chapter will analyze the cases to
identify: (1) the common factors among the cases that
contributed to the endeavor; (2) the mix of resources that
contributed to the collective action; and, (3) what holds
the groups together to continue operation of the centers
by community people. While a health center was
established in each area, the specific nature of the
actions and the level of participation in the action by
neighborhood folk varied across the three neighborhood
organizations. The events within each neighborhood and
across the three neighborhoods will be analyzed to
identify commonalities and differences. Theoretical

237

Table 6.1
Conversion Factors

	Neighborhood	Extraneighborhood
		National and State
	Population characteristics	Dominant ideology
Contextual	Shared values and experiences	Laws and constitution
	Neighborhood Resources	
	Opportunities for interaction	Political Culture
	Preexisting organizations	
		City
	Leadership	Local Government
	Organization	CAAP
Situational	Information and decision making	Institutions
	Motivation	Private foundations
	Resources and linkages	

(Adapted from Henig, 1982)

implications will be discussed for both the individual

neighborhood level and the extraneighborhood levels.

EXTRANEIGHBORHOOD FACTORS

Effects of extraneighborhood factors flow from the national and state to the city and then continue on to affect the neighborhood contextual and situational factors. Because the groups were all in one city and started within a few years of each other, they were affected by the same extraneighborhood factors.

National and State

While this study considers the effects of the larger political systems, it makes no attempt to explain them. National factors were of major importance for the development of the health centers, but the state had almost no impact.

Dominant ideology. The inner city neighborhoods were greatly affected by the changes in the national political environment (Jenkins, 1983; Henig, 1982). The 1960s and the shift from right to left in politics created an atmosphere and an ambience that supported activists in their claims for changes in the distribution of resources and a positive response to those claims by Congress (Hardin, 1982; Henig, 1982; Gamson, 1990). National leaders had ideologies that supported local communities organizing to address their own needs. The influence of political ideology on other institutions, particularly the Methodist Church, is evident in the acceptance and support

of community activist roles for ministers in the
neighborhoods around their assigned churches.

Laws and constitution. The federally sponsored Model
Cities Program and the "war on poverty", in general, laid
a foundation for action by poor people on their own
behalf. The 1964 OEO legislation that supported community
operated health centers added support to the legitimacy of
neighborhood residents forming groups to pursue health
services for their area. One of the early intentions of
the neighborhood health center legislation was to increase
the participation of community residents in the operation
of local services - empowerment of the people. Alterations
in the legislation governing health centers now structure
the citizen participation to such a degree that it may
impede development of services to meet the specific needs
of the community and, indeed, may impede participation.

Other changes in the political environment, started
during the Nixon administration, challenged health center
advocates to maintain the gains they had made. Movement
of the responsibility for NHCs at the national level to
the more conservative DHHS in 1978 eliminated some of the
more progressive aspects of health centers, but has
institutionalized health centers as a legitimate means of
providing health care in low income neighborhoods.
Legislative changes requiring majority consumer

240

participation on the boards created a permanent mechanism that allowed neighborhood residents to maintain control over the health centers.

When the neighborhood health centers responded to Congress' NHC initiative, they exchanged certain governing powers and certain forms of control over their own definition as institutions. In return, they received sizeable federal grants. The centers adopted DHHS' modified definition of citizen participation, which had the potential to negatively affect consumer influence in health center governance. However, the three health center boards presented here appear to have considerable influence on policies in their health centers.

Political culture. Neighborhood health center boards, working through national associations, have successfully lobbied members of Congress and maintained a level of federal funding that helps to keep the centers in operation. Broader concerns about health care in the United States suggest that a sufficient level of funding will continue in the future. City

The structure of local government had changed in 1970 to a county wide government, UNIGOV. The newness of the system may have left the decision making structure more vulnerable to demands from neighborhood groups. Deteriorating economic conditions of the inner city were

in some part the effect of local government policies that emphasized growth and development in the suburbs. Dominance of the Republican party in the city for a twenty year period limited access of inner city residents who tend to support the Democratic party. In the SouthEastside neighborhood this was overcome through the actions of one resident, Lester Neal, who was a minor Republican party official from the otherwise Democratic neighborhood. In other neighborhoods, residents turned to organizations not dominated explicitly by political affiliations.

The Health and Hospital corporation (H&H), as a part of local government, provided the initial services at Barrington and later withdrew which could have eliminated the services. H&H's structure as a municipal corporation with an appointed board protects them from all but the most vociferous demands of neighborhood people. H&H plays a negligible role in NHCs now, serving as a pass through for CDBG funds, which are a minor (and decreasing) portion of the centers' budgets.

The local CAAP agency was supportive of many community empowerment projects and provided funds for community organizing staff in the NE and for staff to start the health center in that area. Interested CAAP workers also served on the health center board. As the health centers have become institutionalized, their

relationship to CAAP has changed. The organizations
sometimes compete for the same set of local dollars to
provide services to clients.

Institutions have some of the tangible resources that
are required by resource poor neighborhood groups.
Indianapolis is fortunate to have a diverse set of
institutions that are supportive of selected community
activities. Methodist and Presbyterian churches provided
resources, including leadership, to health center related
groups that were essential to their success.

The support of most hospitals in the city has varied
over time and sometimes required pressure and threats by
group members to obtain needed resources. In exception to
this, Methodist Hospital, when pressured, responded with
resources and has continued as a resource. Methodist
Hospital administrators during the early years of the
health center may have been supporting their individual
social reform agenda when they provided guidance to the
health centers.

While giving support to SEHC and BHC during the early
years, Methodist Hospital is now on the receiving end.
Since the development of HealthNet with its large budget
(now over $4 million), the hospital claims credit in their
annual report for the centers' activities as part of their
ambulatory care program. HealthNet board meetings are

sometimes battle zones, where Board and staff struggle for control.

A civic sense exists in Indianapolis that is not present in all cities, which is not to say that there are not major problems in the city. Private foundations (notably the Lilly Endowment, Indianapolis Foundation, and more recently the Health Foundation) have made responsible investments in the city, including in the neighborhood health centers. The boards have a continued pattern of interaction with the foundations and fairly regularly receive funds for specific projects.

NEIGHBORHOOD CONTEXTUAL

Neighborhood contextual factors are the relatively stable features that only change slowly with time (Henig, 1982, p.65). They affect how residents interpret and respond to opportunities and threats in the area.

Population

The railroads influenced the development of the neighborhoods and the types of people who settled in the three areas, bringing working folk into the neighborhoods. Later, the development of the interstate highway system through the city permanently altered the neighborhoods, creating new boundaries and sometimes limiting access.

The neighborhoods are similar in having heterogeneous populations with a low level of resources

among many residents, high transiency within the neighborhood, and Appalachian background of residents. The neighborhood populations compare poorly with the total county population: more people live in crowded households; fewer persons have automobiles; almost twice the percentage of persons have incomes below the poverty level; and, fewer persons have graduated from high school (see Appendix E).   Although more affluent neighborhoods are known to be able to mobilize resources easier than low income neighborhoods, the latter group can be effective if they are able to obtain the resources needed.

Scholars take different positions about the effects of homogeneity and heterogeneity of the population Davis (1991) maintains that homogeneity of the population positively affects formation of a group, because persons who are similar will have more shared values and experiences and be easier to mobilize. Henig (1982) explicitly identifies <u>cultural</u> homogeneity as an important population characteristic. On the other hand, Oliver and others (1985) argue that a heterogeneous group can produce the critical mass of people needed to generate collective action. Members of the critical mass diverge from the average, having a higher level of interest and resources. The latter position better explains the collective action in the three neighborhoods.

Barrington differs from the other two neighborhoods, with a higher percent of black residents and with leadership came from the black residents. Racial composition of a neighborhood affects collective action because black persons have a lower participation rate, 60% of the white rate (Thomas, 1986, p.53).

Health care was a highly valued good in these neighborhoods and a high level of agreement existed about the need for health services among a group of people large enough to take action. The importance of health care to individuals cannot be equated with membership in a professional organization. While Olson's (1965) theory may well explain individual behavior in the larger situation where the implications for the individual are distant, the lack of health care is a threat to survival and allows for consideration of additional factors.

Neighborhoods can be conceptualized in more than one way. From one view, they constitute large groups of individuals, many of whom would benefit from health services. However, neighborhoods can be disaggregated into many small, mostly informal groups that interact on a regular basis and provide a mechanism for social pressure to participate in collective activities.

The neighborhoods were long established and had identities separate from the city as a whole. Although sometimes split into sub-communities, each area's

residents still had a concept of the neighborhood as a set of relationships among people which created a whole. The sources of neighborhood identity were different in the three areas, a shopping area and a fountain in the Fountain Square area, an apartment complex in the Barrington area, and a more nebulous "sense of neighborhood" on the NearEastside, but served the same purpose. At the same time, differences sometimes divided the groups. Members had similar experiences and problems in trying to obtain social services, yet were unable to agree about how the services should be provided.

Shared ideologies can consolidate groups that have seemingly different interests (Davis, 1991). The shared views about the importance of health care brought together people with other diverse interests who were willing to put aside the other interests to obtain the health services.

Prior to mobilizing, the sense of their neighborhoods as neglected by city government did not lead to anomic responses but to action. The three neighborhoods could be classified as parochial (Warren & Warren, 1975), having high levels of interaction within the neighborhood and a sense of disconnection with the outside world.

Opportunities for Interaction

Communities in which members interact for other purposes (for example, religious or social) are more

likely to conduct successful collective actions (Crenson, 1987; Jenkins, 1983). The neighborhoods had mechanisms (both formal and informal) for interaction among residents. The Fountain Square shopping area facilitates interaction in the SouthEastside area, and grassroots based organizations are channels for communication in both the SouthEastside and NearEastside areas. Churches are a major feature in all three neighborhoods and provide opportunities for interaction within the congregations. An informal "grapevine" served this purpose in the Barrington neighborhood, but has shortcomings because it may not be open to all persons and may serve to limit who gets information. Nevertheless, persons living in each of the neighborhoods interacted with other community members and were aware of the shared problem.

An existing organization on which to build contributes to successful collective action (Jenkins, 1983). Existing groups alter the context in which the individuals make decisions to participate and increase the opportunities for interaction (Crenson, 1987).

While the neighborhoods had undergone changes imposed by the larger community, (e.g., interstate highways) which altered their physical nature, the changes also served as catalysts and challenged the residents to work together for the benefit of the community. A group of local residents had been developed in each neighborhood to

address these shared concerns. The collective identity

they developed and the increased level of interaction

among group members created a supportive environment for

the pursuit of health services for their neighborhoods

(Jenkins, 1983) .

The three neighborhoods can best be characterized as

low resource areas. However, each of the neighborhoods

can also be considered asymmetric, with material

resources distributed unevenly throughout the

neighborhoods. Neighborhood institutions are a major

resource in the SE and NE areas, but play a negligible

role in Barrington. The major resource in Barrington is

the people.

SITUATIONAL FACTORS

To this point I have been reviewing the broad

background within which individuals wanted to solve a

problem. While the settings had some positive features,

the residents needed assistance in initiating the

collective action. These efforts require more than

assembling all the right parts in one place; humans with

vision are required to direct the assembling of the

resources, identify gaps, and provide access to other

resources needed. The situational factors are causally

closest to the collective action and are the actors'

perceptions, behaviors, and interactions. Henig's model

offered only two situational factors, leadership and
mobilization. Events in the three areas studied were not
sufficiently explained by two factors leading to changes
and additions in the situational factors.

<u>Leadership/Entrepreneurs</u>

Leadership is a crucial factor for mobilization for
collective action (Henig, 1982). Davis (1991) confirms
the importance of leadership and goes on to suggest that
it is also the most theoretically elusive and empirically
unpredictable variable. Leadership for collective action
is more than someone simply taking charge of the events.
Leadership for collective action in low income areas
requires individuals with creative energy who know how to
create and obtain access to resources and who are not
timid about using unconventional tactics (Lachman, 197 8).
In the long run, whether leadership comes from within the
group or from outside is less important than whether or
not it is forward looking, problem solving, and develops
indigenous leadership.

The high demands made on leaders in low resource
areas create instability in leadership over time (Rich,
1980). Burnout among leaders can be anticipated in a
shorter time period than in more affluent areas.
Consistent with previous research (Davis, add others)
leadership was an essential factor in the development of
the three neighborhood organizations that addressed

250

neighborhood concerns. An entrepreneurial model of leadership, in which the focus is the availability of resources, is most appropriate for groups with low levels of resources (Jenkins, 1983).   Individuals were needed to modify the social organizations, and an extended version of the entrepreneurial model of leadership emerged in each of the neighborhoods. This model, as presented by Henig (1982, p.182), describes leaders as: perceiving needs and originating the idea of an organization, contributing in other ways toward maintaining the ongoing organization, and motivated by material or nonmaterial gains or simply liking to lead.

The low level of resources among neighborhood residents, knowledge and skills as well as money, limited the actions that individuals could take and their ability to develop an organization to initiate collective action. The initial leaders in the actions to obtain health services in the SouthEastside and NearEastside neighborhoods were outsiders (funded by CAAP and the Methodist Church) whose goals included improving conditions for neighborhood folk. In Barrington, indigenous leaders were present and had a higher level of skill and knowledge than many other Barrington residents.

Leadership cadres and organizing facilities are especially important for low income groups to be successful in collective action (Jenkins, 1983). Because

neighborhood resources are low, leadership must have or be able to establish linkages to resources outside the neighborhood.

In each area, the leaders had been specifically trained for their task or had experiences in similar situations. They brought knowledge of tactics, organizational skills, and the type of people or resources that were important for the success of the project. With the guidance and support of the leaders the community members were able to force their issues onto the agenda of the elites. While neighborhood folk believed what they were doing was unique, the model was actually carried into the community by professional organizers and activists.

When money resources are in general very limited, adequate human resources become more important. Leaders, in their role of obtaining resources, create incentives for participation based on the different motivations among the group members. Times occurred in each organization when the health centers were operating in a routine manner without threats from any source and attendance would decrease to almost zero. The role of leadership during these uneventful times is to maintain a small cadre of members who can provide the linkages to other neighborhood residents when a crisis occurs and when major decisions must be made. Crucial to moving back and forth from smaller to larger membership is, beyond obvious

crises, correct assessment of what situations the larger group would define as a crisis.

Operating the health centers creates new challenges for leaders. In many of the organizations, members are content to leave the conceptual work to a select few, but will participate eagerly in physical activity supportive of the organization (e.g.,painting, landscaping, garage sales, baking, cleaning). The challenge to leadership is to coordinate the two groups of people so that there are <u>linked</u> activities for them that provide opportunities for validation of each group's efforts. <u>Organization</u>

Neighborhood residents can be differentiated into a number of "quasi groups", with each having a different set of interests (Davis, 1991, p.272). One of the first acts of a leader must be to establish consensus on the issue and to mobilize a group around the issue. While lack of consensus makes collective action impossible, having consensus contributes to success of the action but does not guarantee it (Olson, 1965, p.196).

The right issue can catalyze neighborhood political involvement despite previous lack of organizational resources (Thomas, 1986, p.109). Each of the neighborhoods had successful organizations, although based on consensus regarding other collective issues, and

therefore the likelihood of success related to health centers was increased.

To achieve the consensus mobilization necessary for action (Klandermans, 1984), leaders must articulate the issues in a way that reduces social distance between the people in the various quasi-groups and can be viewed as a common problem. The existing organizations provided a framework to pursue the new collective interest, health services. Widespread agreement existed about the value of health services and that it was a collective problem, not an individual one. The need for health service was perceived as clearly in the interest of individuals and the neighborhood, with little tension between individual and collective interests (Henig, 1982, p.198). Obtaining health services was an issue that further solidified the neighborhood group.

Each group developed organizational structures that encouraged a high level of participation by members, with many officers and committees. Tactics introduced by leaders provided other opportunities for involvement. The demands made on the institutions and government for assistance in developing the health centers assumed that their decision making processes were open and could be influenced (Henig, 1982). The question then becomes how to approach these groups in the broader community. ,

254

Gamson (1990) suggests that the willingness to use tactics other than those institutionally approved leads to successful collective action. Each of the neighborhood groups used tactics such as picketing, mass attendance at meetings, disruption of meetings, and "skin games" to achieve their goals. Willingness to stage confrontations and to cooperate with the media expand the awareness of a neighborhood situation, and when done carefully, can generate support from more powerful groups.

Time has passed and the health centers and associated boards have become institutionalized and use more formal bureaucratic structure to obtain resources and concessions. Although this may contribute to their stability in the community, it may also inhibit present and future grassroots participation in decision making for the organization.

As grass roots organizations, the health center boards have not affected decision making related to other social concerns. The health center boards have not, of their own volition, spun off other organizations.[1] When services are the focus, advocacy on other issues takes a back seat (Waitzkin, 1983). The neighborhoods, in general, continue to lack an overall organization. While NESCO has survived as an organization in the NearEastside area, insufficient representation from among some segments

of the population, especially renters, limits the organization's effectiveness in the neighborhood.

In operating the health centers the boards are no different from other participatory organizations. There is a high level of participation by a few members, and a low level of participation by the majority of members. The real issue is, will the majority of the members support the decision made by the few and will they respond when they are called on for activities requiring a large body of people.

The very nature of health care creates problems for citizen involvement in the management of the health centers. An attitude existed among some staff and board members that, once the facility was in place, community residents should have allowed the professionals to run the centers. If residents see only the technical aspects of health care, they may assume that no role exists for them. On the other hand, if they are able to separate the technical aspects from their role of ensuring that both the nature and manner of provision of the services are responsive to community needs, a role clearly exists.

Information and Decision Making

Decisions to participate are affected toy knowledge about the collective good and expectations about other people's participation (Klandermans, 1984). Neighborhood residents had high levels of knowledge about health.

services, in general, and less information about health
centers. Some individuals make the decision to
participate and when others learn of this decision, some
of them will follow (Klandermans,1984; Oliver, et
al.,1985). In the SE and NE areas, the high levels of
interaction among neighborhood residents provided
validation of expectations for others' participation. In
Barrington, the tightness of the group promoted
interaction and almost guaranteed participation.

Information is important in operating health centers,
as well as starting them. Correct information is
necessary to political conditions and actions that lead to
the group's survival (Henig, 1982). All three groups rely
on the health center staff for information. As the health
centers increase in size, become more sophisticated, and
as the professional staff increases, the board members
become isolated from the operation of the centers.
Decisions become more technical and some are conceded to
the staff. While PHC board members believe they have an
acceptable level of information to make good decisions,
BHC and SEHC board members are sometimes critical of
information provided by staff. Many board members accept
staff decisions because they feel they do not know enough
to challenge what is planned.

<u>Motivation</u>

The decision to participate in the groups developing neighborhood health centers would not be interpreted by some observers as rational if one limits the definition of rationality to economic rationality. If one broadens the concept of rationality to include concerns for the future and for others, and does not presume perfect information, the decision is not so clear cut.

The health services would be of great benefit to many of the individuals in the neighborhoods, not just immediately, but into the future for whoever lived in the neighborhoods. Moral motivation, seeing health care and empowerment as a right of the people, and a sense of justice and fairness were other themes that emerged from participants and are motives that have supported other collective action (Moe, 1980). In addition, participants also expressed concern for the unfairness of the system that did not provide access to health care, and were determined to make the system more fair for others. Leaders play an important role in contributing to the production of collective goods when persons are guided by this type of motives (Hardin, 1982),

As Marsh suggests, individuals do not always have access to complete information about the situation, nor do they pay attention to all the information. This was true

in the three neighborhoods where some participants

admitted they did not know what they were "getting into".

   Multiple motives can be operation at the same time

and can combine so that if one motive is weak or negative,

it may be compensated for by another motive (Klandermans,

1984) . Both purposive and solidary incentives (Clark and

Wilson, 1961) were part of the motivation to participate.

Most participants were driven by their support of the

highly valued ends being sought, that is, by purposive

incentives. However, the high levels of interaction in

the SouthEastside and NearEastside allowed use of solidary

incentives to gain and maintain participation. Friendships

were used to persuade people to join. In other cases,

some persons joined the group after seeing or hearing

about other participants' activities and wanting to be

part of the neighborhood action.

Although membership in the Watotos was limited,

participation from other neighborhood residents was

necessary to lend credibility to the demands being made

and to demonstrate to the larger community that the group

represented the neighborhood. The elements of solidary

and purposive incentives apply in this situation also.

Some participants are committed to the collective action

because of loyalty to the community (Gamson, 1990). Those

who identify with the collective action will make greater

investments, even self-sacrifices, for the

collective interest. The health center groups sought to identify the individual and the group interest to such a degree that the individuals experienced personal pleasure from the achievement of the collective good.

Movement from purposive incentives at the time of inception of the health centers to solidary incentives occurs when they are running smoothly. Purposive motives play an important role in maintaining operations of the health centers and have not given way to solidary motivation as is suggested earlier research (Clark & Wilson, 1961). People who serve on the boards still have as their goal the provision of health services in the area. The likelihood of solidary incentives is reduced by turnover in board membership due either to bylaws requirements or voluntary departure from the board. Changing membership helps to maintain the purposive nature of the motivation as new members are recruited based on their commitment to provision of health services.

The boards have little opportunity or resources to use selective incentives. The extensive use of committees and long lists of officers used by some boards provide selective incentives to some members as do the occasional trips to national meetings.

Persuasion is used (Gamson, 1990), and joked about as "arm twisting", to convince some residents to become board members. Challenges are made about demonstrating loyalty

and commitment to the neighborhood and claims made for the importance of the health services. In current membership recruitment, board members are honest about the time commitments, recognizing that some self sacrifice will be necessary among members. Resources and Linkages

Especially when financial resource levels are low in the community, some highly interested or highly resourceful persons can provide a cadre of workers although the general level of interest or resource is low (Crenson, 1987; Hardin,1982). Lachman's (1978) notion of the complementarity of resources is well exemplified by the three groups. When individuals in the NearEastside and SouthEastside areas lacked material resources, they sought assistance from institutions from within and outside the neighborhood, as well as residents contributing their own labor. Entrepreneurial leadership guided residents in obtaining resources from local government and foundations.

In Barrington, local monetary resources were even more limited, especially in terms of neighborhood institutions. Demanding that H&H initiate health services in the neighborhood may reflect not only the model of their organization, but a realistic assessment of the mixture of resources available to them within the neighborhood.

The neighborhood health centers originated as free-standing, independent organizations. When organizations operate in isolation, they can gain strength when linked to other institutions that create revenues or otherwise provide some financial stability (Waitzkin, 1983). For PHC, the price of total autonomy has been a struggle for financial stability. Without an association with a larger institution, PHC is more greatly affected by delay in receipt of federal grants or other anticipated funds. The SEHC Board achieved an institutional linkage from the start by their link to Methodist Hospital. Barrington was started not as an independent center, but as part of the health department. When that relationship ended, Methodist Hospital also provided stability for them. Development of HealthNet more firmly established the relationship of the hospital with Barrington and SEHC. The other side of the coin is that the relationship creates difficulty in maintaining autonomy in decision making related to the policies and operation of the centers.

EXPLAINING SUCCESS

The people involved in the collective actions would not be described as being powerful but they were able to achieve their goals. Can success be measured in this limited manner or should larger changes be considered?

The success of the neighborhood folk should not be devalued because they did not pursue additional collective goods. The continued operation of the health centers, the maintenance of neighborhood control over health center policy, and the growth of the centers in terms of services provided and clients seen argue for viewing the collective actions as success in a broader sense. In addition, the participants have engaged in self governance of organizations that have endured for almost twenty years. Some participants have used those skills in other neighborhood and city organizations. Those persons involved in the health centers have built for themselves, and their neighborhoods, an important social and capital structure.

Social science theories predicting that these actions would never have occurred lose their power in this situation. What is needed is a theory that will explain how these successes occurred and to predict when other collective actions by low resource groups will be successful. The interpretation of the results of this study is limited by the small number of cases (3). Since all the cases were successful in their collective actions, it is not known if the conditions are sufficient to produce success. This study relied heavily on personal interviews with neighborhood folk who had been or are involved with the health centers. Because the centers

263

started over twenty years ago, memories may not have been as accurate as desired. To the degree possible, multiple sources of data, including historic documents, were used to validate information. When discrepancies could not be eliminated, both positions were presented.

The concept of collective action that has been presented here is very broad. A variety of factors contributed to the successful actions in the three neighborhoods. Based on these experiences a tentative set of conditions can be hypothesized that, at a minimum, are needed for successful action that both initiates neighborhood services and maintains them in the long run.[2]

The conditions identified all emerged from the neighborhood factors. While the factors in the other categories are important to the collective action, they are not amenable to change by neighborhood folk within the context of an action situation. It is assumed that resources are available in the extraneighborhood arena if the neighborhood group uses the right tactics to access them. Each of the conditions will be presented and discussed briefly.

The collective good (health services) is highly valued. Neighborhood residents must be aware of the collective good and it must be very important to them.

The neighborhood has mechanisms for interaction and communication among most members. The decision to

participate is made within the a social context and is affected by expectations of others' behavior (Hardin, 1982; Klandermans, 1984; Oliver, Marwell, & Teixera, 1985). However, potential participants in the collective action have imperfect information about the collective good and the potential participation of other neighborhood folk (Moe, 1980). Mechanisms for transmission of information assume added importance in this situation.

The awareness that a concern is shared and desired highly by various persons facilitates movement from a private concern to a public good. When people interact on a regular basis, information will be more open and knowledge about others' concerns acquired more quickly. Interaction also facilitates group operation of the services. Lack of interaction networks contribute to rumors and the development of suspicion.

Wide consensus exists about the end to be achieved. Consensus mobilization, agreement about the purposes of the organization, must occur before action can be initiated (Klandermans, 1984). Collective action <u>for</u> a service has problems not associated with action against others' actions. The effectiveness of nontraditional tactics can be lost if participants are diverted by disagreements about ends. As a service that is to be maintained, long term as well as short term consensus and support are required.

Leadership is available and, in the face of low resources, willing to use other than institutionally approved tactics. Leadership in low income areas requires greater sacrifices than in more affluent neighborhoods, functioning in an entrepreneurial mode to mobilize latent groups (Frohlich, Oppenheimer, & Young, 1971; Lachman, 1978; Jenkins, 1983). The nature of the leadership is a crucial factor. It is not just directing others to do things, but also creating an understanding of why it is being done.

Leadership is essential for low resource groups, not because the individuals are inadequate but because someone has to be in charge to identify resources in the broader environment, use creative tactics to obtain the resources, and provide incentives to members (even if it is opportunities to participate with everyone else in protests) (Jenkins, 1983; Gamson, 1990).

Residents are willing to put aside differences to work toward the collective good. Although residents are working towards achieving a collective good, differences on other issues remain. The high value of the good will give it primacy over other issues. When differences are not put aside, disagreements will interfere with pursuit of the collective good. Individuals are guided to some extent by personal motives and how significant others will respond to them. However, they also have feelings of

266

public or social responsibility and concern for others' welfare (Fleishman, 1980: Henig, 1982; Klandermans, 1984).

Residents are loyal to the neighborhood and committed to starting and operating the services. Working for collective goods in low resource neighborhoods will require greater commitment and self-sacrifice then in more affluent neighborhoods (Rich, 1980b). Loyalty to the neighborhood and commitment are incentives that look beyond the benefits to the individual and focus on the benefits to all residents (Gamson, 1990). The level of commitment is sufficiently high that participants continue to pursue the collective good even when cost-benefit analysis for the individual yields a negative value.

Leaders work with members to develop social capital. Leaders, as individuals, are transient in their positions. For long term success, new leaders from within the neighborhood must be developed to take their place. Other social capital to be developed includes skills in operating the organization, interacting with professional staff and institutional elites,and providing incentives to neighbors to engage in the collective process.

DIRECTIONS FOR FURTHER RESEARCH

Studies of a broader set of cases are needed. Cases
should include unsuccessful attempts as well as success in
other cities and neighborhood contexts. The large number
of health centers operated by community boards throughout
the country offer an opportunity to address the first
problem. Three other types of cases can add to the
knowledge developed in this study. In the search for a
failure, a failed attempt in northwestern Indiana could be
examined to assess the role of the hypothesized conditions
and other factors.   Instances that exhibit a lesser
degree of control by the neighborhood folk can provide
additional insights into the relevance of the hypothesized
conditions. One case of this type exists in Indianapolis
and allows examination of the role and presence of the
conditions. In addition, this case allows one to consider
if neighborhood control has an effect on the nature of the
services and their use by residents. A third variation is
offered by community groups attempting to develop
neighborhood health centers in the present political
context. If all the conditions are present, will they be
sufficient in a different political context? Events
allowing study of this question are underway in southern

Indiana, where a community group is proposing that a new health center be started.

The three variations identified address only three of the possible outcomes of collective action for neighborhood health centers, and will expand understanding of the role of the conditions of extraneighborhood and neighborhood factors. Additional cases can be identified through communication with activists in other communities.

1. HealthNet could be conceptualized as a spinoff, but was created at the insistence of the federal government and was not the choice the local health center boards would have made if left to themselves.

2. The conditions identified are, in some respects, similar to those presented by Elinor Ostrom (1990) in her work on institutional choice by common pool resource organizations. Although these organizations are much larger than neighborhoods, they frequently build on smaller locality based organizations with characteristics similar to neighborhoods.

REFERENCES

Alford, R.R. (1975) Health care politics: Ideological

and interest group barriers to reform. Chicago:

University of Chicago Press. Clark, P. & Wilson,

J.Q. (1961). Incentive systems: A

theory of organizations. Administrative Science

Quarterly. 61, 129-166. Crenson, M.A. (1987) . The

private stake in public goods:

Overcoming the illogic of collective action. Policy

Sciences, 20, 259-276. Davis, J.E. (1991).

Contested ground: Collective action

and the urban neighborhood. Ithaca, NY: Cornell

University Press. Feingold, E. (1970). A political

scientist's view of the

neighborhood health centers: A new social

institution. Medical Care, 8., 108-115. Fleishman,

J. A. (1980). Collective action as helping

behavior: Effects of responsibility diffusion on

contributions to a public good. Journal of

Personality and Social Psychology, 18.(4), 629-637.

Frohlich, N., Oppenheimer, J.A., & Young. O.R. (1971).

     Political leadership and collective goods.

     Princeton, NJ: Princeton University Press.

Gamson, W. (1990) _The strategy of social protest_ (2nd

     ed.) Belmont, CA: Wadsworth. Geiger, H. Jack (1984).

Community health centers: Health

     care as an instrument of social change. In V.W.

     Sidel, & R. Sidel (Eds.), _Reforming medicine:_

     Lessons of the last quarter century (pp.11-31). New

     York: Pantheon Books. Hardin, R. (1982). _Collective_

action. Baltimore: Johns

     Hopkins University Press. Henig, Jeffrey R.

(1982). _Neighborhood mobilization:_

     Redevelopment and response. New Brunswick, N.J.:

     Rutgers University Press. Hessler, R.M. &

Beavert, C.S. (1982). Citizen

     participation in neighborhood health centers for the

     poor: The politics of reform organizational change.

     Human Organization, _41_, 245-255. Hollister, R.M.,

Kramer, B.M., & Bellin, S.S. (1974).

     Neighborhood health centers as a social movement. In

     Hollister, Kramer & Bellin (Eds), _Neighborhood health_

     centers (pp. 13-24). Lexington, MA: Lexington Books.

272

Jenkins, J.C. (1983). Resource mobilization theory and

  the study of social movements. Annual Review of

  Sociology, 9., 527-553. Klandermans, B. (1984).

Mobilization and participation,:

  Social-psychological expansions of resource

  mobilization theory. American Sociological Review,

  49, 583-600. Lachmann, L.M. (1978). Capital and its

structure. Kansas

  City, KS.: Sheed Andrews and McMeel, Inc.

Marsh, D. (1976). On joining interest groups: An

  empirical consideration of the work of Mancur Olson,

  Jr. British Journal of Political Science, 6., 257-

  271. Moe, T.M. (1980). A calculus of group

membership.

  American Journal of Political Science, 24(4) , 593-

  632. Oliver, P., Marwell, G., & Teixera, R. (1985).

A theory

  of the critical Mass. I. Interdependence, group

  heterogeneity, and the production of collective

  action. American Journal of Sociology, 9_1(3) , 522-

  556. Olson, M. (1965). The logic of collective

action: Public

  goods and the theory of groups. Cambridge, MA:

  Harvard University Press.

Ostrom, E.). (1990). <u>Governing the commons: The</u>
    <u>evolution of institutions</u>. New York: Cambridge
    University Press. Ostrom, V. & Ostrom, E. (1978).
Public goods and public
    choices, in E.S. Savas, (Ed.), <u>Alternatives for</u>
    <u>delivering public services: Toward improved</u>
    <u>performance</u> (pp.7-49). Boulder, CO: Westview Press.
Piven, F.F. & Cloward, R.A. (1977). <u>Poor people's</u>
    <u>movements: How they succeed, how they fail</u>. New
    York: Vintage Books. Ray, D.W. & Selmanoff, E.D.
(1984, October). <u>A low cost</u>
    <u>methodology to assess community health needs</u>.
    Presented at the annual meeting of the American
    Public Health Association, Anaheim, CA. Rich, R.C.
(1976). <u>The political economy of neighborhood</u>
    <u>organization</u>. Doctoral dissertation, Indiana
    University, Bloomington. Rich, R. C. (1980a).
The dynamics of leadership in
    neighborhood organizations. <u>Social Science</u>
    <u>Quarterly</u>, 69.(4), 570-587). Rich, R.C. (1980b). A
political-economy approach to the
    study of neighborhood organizations. <u>American</u>
    <u>Journal of Political Science</u>, 24(4) , 559-592.
Salisbury, R.H. (1969). An exchange theory of interest
    groups. <u>Midwest Journal of Political Science</u>. 13(1),
    1-32.

Sardell, A. (1982). The U.S. experiment in social

medicine: The community health center program, 19 65-

1986. Pittsburgh, PA: University of Pittsburgh

Press. Starr, P.(1982). The social transformation of

American

medicine. New York: Basic Books. Syme, S.L. &

Berkman, L.F. (1976). Social class,

susceptibility, and sickness. American Journal of

Epidemiology, 104, 1. Thomas, J.C. (1986).

Between citizen and city:

Neighborhood organizations and urban politics in

Cincinnati. Lawrence, KS: University of Kansas

Press. Waitzkin, H. (1983). The second sickness:

Contradictions

of capitalist health care. New York: The Free

Press. Warren, D.I. & Warren, R.B. (1975). Six

kinds of

neighborhoods. Psychology Today, 9.(1), 74-80. Yin,

R. (1984). Case study research: Design and methods.

Beverly Hills, CA: Sage.

APPENDICES

A: METHODS AND SOURCES

B: QUESTIONS ASKED

C: NAMES AND AFFILIATIONS OF INFORMANTS

D: HEALTHNET

E: POPULATION CHARACTERISTICS

276

APPENDIX A METHODS

AND SOURCES

The case study method is used to guide this research. Yin (1981) defines the case study as an empirical inquiry that "investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used." Using the embedded, multiple case study design, I examine three neighborhoods where the residents through collective action, developed and continue to operate neighborhood health centers in one city.

The purpose of this study is to determine the factors that affect collective action in low resource neighborhoods, focusing on the decision situations that occur. Previously developed propositions related to neighborhood mobilization provide insights into collective action related to establishment of neighborhood health centers, but they are not stated in testable terms. However, the propositions are used along with other developments in the study of collective action to guide this study.

The unit of analysis or "case" for this study is the neighborhood associated with the health center board.

277

Embedded within each neighborhood are three units of analysis, forming the group, starting the health center, and operation of the health center. The first two of these are addressed in this study. The data are considered first within each neighborhood. Second, the data are analyzed by decision situation across all four boards. Although information is obtained from individuals, it is within the context of the neighborhood. Time boundaries for the study will be the twenty-seven year period from 1965 to 1991.

The study methods combine review of historical narrative, ethnographic analysis, and political science analysis to examine the formation and operation of neighborhood health center boards. Multiple sources of information were used and whenever possible, multiple sources used to address the each question.

Study questions were developed to guide the data collection process. The study questions are not asked directly but serve to provide direction to the data collection, regardless of the method being used (see Appendix B).

The study makes extensive use of available written records, including minutes of health center board meetings, interoffice correspondence, health center records, and correspondence between health center officials or community board members and the regional and/or central federal government officials. Historic newspapers clippings were

used to supplement other materials and to establish time frames. I had access to one board member's files that documented the start of Southeast Health Center and other events related to health centers in Indianapolis over a 20 year period. Record keeping by voluntary organizations (both recording and storing) is sometimes less than desired for research purposes. Although the Watoto Wa Simbas kept minutes, a fire destroyed them. Much of the information about this group is dependent on recall by two persons. Fortunately, the Watotos had been included in a study of neighborhood organizations by Rich (197 6) that provided supplementary information about the organization and operation of the group.

U.S. Census and local health department reports provided information about the characteristics of each community. Historical information about the neighborhoods was obtained from local branches of the public library.

Focused, in-depth interviews were conducted with health center board members (past and present), medical professionals, and health center administrators. Efforts were made to locate those individuals who were involved in the initial efforts to establish the health centers and in most instances were successful. With the consent of the respondent, interviews were tape recorded and supplemented by extensive note taking. Typed transcripts of the tapes were used for the analysis.

279

In selecting people to interview, I used a key informant method, starting with a president or past president of the board, and asked that person for names of other people to be interviewed. While some persons involved in starting the centers had left the area, local people knew how to contact them and they were interviewed. The number of people I eventually interviewed was fewer than planned. However, the quality of the interviews completed compensated for a larger quantity. For each board, the current and at least one past president were interviewed, as well as other board members. Two persons, both former Watotos, refused to be interviewed. Executive directors were interviewed and other staff also. The individuals interviewed were quite candid in their responses and volunteered information beyond that requested, providing greater depth to the case studies.

I also relied on my own observations of the development of the health centers and neighborhood life. As a faculty in the Graduate Community Health Nursing Program at Indiana University (Indianapolis), I have supervised the work of students in the neighborhoods and attended board meetings as an observer for 15 years. For the past three years I have lived on the NearEastside, observing for myself many of the events described to me earlier in interviews. In addition, I have been an active member of the Barrington Health Center Board (1984-present) and the HealthNet Board (1988 to the

present), and therefore, a participant observer in these

organizations.

QUESTIONS ADDRESSED

Federal government

     What are the federal guidelines for the neighborhood health centers? How have these changed over time? What is the effect of change in national political leadership?

State and local government

     Are there state or local guidelines that must also be followed? What is the structure of the local government and how does it interact with neighborhoods? Health system organization

     What are the characteristics of the existing health care system in the city? Is the health care system in the city an open or closed system? Decision Situation

     How many decision makers are there? What kinds of choices are available? Is the link between action and result clear? How complex is the issue in the decision situation? Has this type of decision been made before? Is there communication among the decision makers? What role does leadership play in the decision situation? Who are the leaders? What are the rules?

<u>Individual</u>

What are the characteristics of the decision makers? What is the level of information among the decision makers? How do individuals value potential outcomes? How do individuals decide which outcome to select? <u>Neighborhood Institutional Arrangements</u>

What other types of organizations are in the neighborhood? Were these organizations involved in development of the health centers? What role do they play in decisions related to the health centers? Do the organizations take an active role in other neighborhood activities? <u>Level of common understanding</u>

Have there been structural changes in the community? (e.g.,housing demolitions and new starts; gentrification; new interstates, shopping centers, industries). What is the average length of time residents have been in the neighborhood and their residence? Have there been changes in the population characteristics? <u>Cultural homogeneity</u>

What is the racial composition of the neighborhood? What is the ethnic background of the residents? Is there socioeconomic diversity in the neighborhood?

What are the organizations in the neighborhood? What is their level of activity? Do the churches in the area become involved in neighborhood issues? Do residents attend neighborhood churches? <u>Past efforts at mobilization</u>

Have neighborhood residents attempted to address other collective problems? If so, what was their success?

<u>information</u>

Is there a neighborhood newspaper?   Is there a neighborhood political office, ward chairman or precinct committeeman? What are the linkages to the local, state, and national governments? <u>Level of common agreement about values</u>

What are the prevalent values in the neighborhood? What is the religious affiliation of neighborhood residents? What is the political affiliation of neighborhood residents?

<u>Distribution of resources</u>

What is the economic status of the residents? (e.g., median income, unemployment rate? Are there persons in the neighborhood who have linkages to the broader political system? Have neighborhood residents previously been involved with the public sector? What is the health status of the neighborhood?

Appendix C

NAMES AND AFFILIATIONS OF INFORMANTS

Name	Organization and Role
Tom Adams	Staff, Chaplain, HealthNet
Barbara Black	Long-time community activist Past President, PHC Board Director, ECI Credit Union
Dale Benson	**Physician** **Executive Director, HealthNet** Executive Director of SEHC and BHC prior to HealthNet
Hannah Briner	Neighborhood activist Past President, SEHC Board
Charles Crenshaw	Former USCO member Member, BHC Board Member, HealthNet
Myrtle Darby	Former President, Clearstream Tenants Council First President, BHC Board Member, HealthNet
Cindy Dillahay	NearEastside resident Past President, PHC Board
Winona Eads	SouthEastside resident Local book store owner Member, SEHC Board Secretary, HealthNet

Carl Glassburn	BHC Board member HealthNet member Nonresident of area
Alice Good	Wife of Methodist minister Member, SEHC Past President, HealthNet
Chris Haile	Member, PHC Board LSO attorney
Jack Hahn	Retired Chief Executive of Methodist Hospital
Pamela Hall	Barrington neighborhood activist Past President, BHC
Debbie Hedges	NearEastside resident President, PHC Board
Leroy Hodap	Methodist Minister Formerly District Superintendent for the Indianapolis area Bishop for South Indiana Conference of the Methodist Church
Carolyn Kaptain	Neighborhood resident Caseworker, Senior Center at SEMSC SEHC member HealthNet member
Pat King	Resident, NearEastside Member, PHC Board Member, Holy Cross Food Pantry Board
Rilda LaVelle	Resident, Brookside Apartments for the Elderly Member, BHC Board
Toni Lawrie	Nurse, Developed and first Director of NESCO Clinic (later PHC)

Karl McClure	Methodist Minister Director, Fletcher Place Community Center Retired Staff, SEHC President, SEHC Treasurer, HealthNet
Maureen McLean	Public Health Nurse Activist, NearEastside Past President, PHC Board Member, Holy Cross Food Pantry Board
Jim Mitchell	Local attorney Former USCO director President, BHC Board Past President, HealthNet
John Murphy-	Former Director, PHC Member, PHC Board
Diane Pfeiffer	Staff, NEMSC
Gene Selmanoff	Faculty, Indiana University School of Nursing Past President, SEHC Board Past President, HealthNet
Ray Sells	Methodist Minister Formerly, Director of Fletcher Place Community Center and pastor at Fletcher Place Methodist Church
Thelma Tookes	Non-resident Member, SEHC Board
Larry Voelker	Community activist Priest in local parish
Jerry Watts	Secretary, Watoto-Wa-Simbas Past President, BHC Member, HealthNet

APPENDIX D

HEALTHNET

HealthNet is an organization that was formed in response to
the federal government's unwillingness to continue granting
money directly to Methodist Hospital for the operation of
the three neighborhood health centers for which they
provided medical and administrative services. SouthEast
Health Center and Barrington Health Center (and a third
center not discussed), were operated by neighborhood
boards with contracts with Methodist Hospital. Methodist
not only provided the clinical services, but also served as
fiscal agent (receiving money from outside sources) and
provided administrative services. In 1982, DHHS expressed
concern about the funding going to a hospital rather than to
community boards. Since Methodist was operating the three
centers, DHHS strongly suggested that one umbrella board be
formed for the three centers and the board become the
recipient of the money. Each of the three health centers
would continue to operate in its neighborhood, but policy
decisions would be made by a central board. The government
agency emphasized that the community board was not to be
just a pass through to Methodist for the money, but must
take a full role as a policy board.

The suggestion was met with great fear and trepidation by many local health center board members. Creation of a central board was seen as taking power away from the local boards and reducing local community input into the running of the health centers. However, the suggestion was also perceived as a threat to cut off funds to the three centers if changes were not made in the community board structures.

Discussion about the formation of the new organization began in 1982 continued over a two year period of time. A task force to accomplish the development of the "Central Board" was composed of two board members from each of the local health center boards and one Methodist Hospital staff member, plus the board attorney. Task force members included: Gene Selmanoff and Alice Good from Southeast, Barbara Cross and Carl Glassburn from Barrington, 2 members from the third board, and staff member, Pete Townes.

The contract with Methodist Hospital was a major issue and consideration was given to establishing the Central Board as an employer, hiring the personnel needed to run the health centers. As a professional colleague of one of the local board presidents who was a member of the task force, I was asked to provide input into the proposed structure of the organization. I argued that the only way for the Central Board to have control over the facilities was to be the employer. That position was not shared by my colleague or the majority of task force members and the new

organization was developed based on contracting with an outside organization to serve provide administrative and clinical services. The contract has continued to be with Methodist Hospital to the present.

A major hurdle to be overcome was the division of responsibility between local boards and the central board. Bylaws went through [6 or 8] drafts before approaching acceptance by local board members. After additional compromises were made and concessions given to local board autonomy, a set of bylaws (see Appendix) was produced that completely satisfied no one, but neither did they offend too greatly. As stated in the bylaws, any power not expressly given to the Central Board, remained at the local level. However, if action were needed immediately the Central Board Executive Committee could act and retroactively take the decision to the local boards, a condition that had implication for later changes in structure that occurred. After almost a year of biweekly meetings and consultation

with DHHS Region V attorneys, the new organization was established and began receiving operational funding in 1984. A contest was held among members of the local boards and **the** name Community Health Network, with the acronym of HealthNet, was the winner.

The Healthnet (HN) Board began to meet and for the majority of the members was an additional responsibility and time commitment. The new board was constituted of 3 members

from each of the local boards and two at large members and
was to be a full policy making board. HN board membership
had to meet the federal criterion that a majority of the
members be consumers of the services. Scheduling of HN
meetings had to be squeezed in among the local board and
committee meetings.

The first meeting of the HN board was held on January
19, 1984. The first HealthNet Board was composed of three
members from each of the three participating local health
center boards and two at large members. Members from the
local boards were elected by their board membership for
terms of three years and were limited to two consecutive
terms. Those persons first elected to the HealthNet board
were longtime members of the local boards and were strong
advocates for their local issues and their "right" to gain
approval of the local board for decisions made by the
HealthNet Board. Members from the local boards strove to
ensure that their particular health centers were not
slighted in the allocation of resources. In the early days,
attempts were made to divide the budget and allocate amounts
to individual centers. Since the administrative function
was centralized, these allocations were on paper only and
not in fact. Decisions about spending money were retained
by HealthNet and not the local boards.

The first HealthNet members were motivated by their
commitment to health care services for their specific

neighborhood and perceived participation in HealthNet as an extension of their participation on the local board.

Meetings during the first year were staffed by the head of the chaplaincy service, with other staff occasionally attending and identified in the minutes as "guests". The first few meetings focused on organizational issues such as: assignments to standing committees, signing contracts, amending bylaws to allow payment of rent, and affirmation of existing policies. Contracts were renegotiated so that HN was the signatory rather than Methodist Hospital.

During the first year a sliding fee scale was approved and fee increases. That same year, fees were increased a second time to meet DHHS guidelines. Even after the second increase in fees, Dale Benson (executive director) maintained that charges were too low, beginning a disagreement between board and staff that continues to the present.

The use of the payment in advance policy (PIA) was discussed. The PIA policy requires that patients who have not made payment on their bills for four months pay in advance for services, and had been an issue with local boards. In June, 1984, the HN board proposed that each neighborhood board develop its own PIA policy, and took no formal action on the issue. In July, 1984, the HN board assigned staff the responsibility for final review of the PIA list after approval by the local boards.

Other important issues during the first year were the approval of a job description for a Community Nurse Outreach Worker, reimbursement of out of pocket expenses for HN members whose incomes were below the poverty level, and establishing outreach services.

Some dissension continued among board members as to the role of the HN board in representing local issues. The HN board was required to send a representative to the H&H Neighborhood Health Center Program panel to determine the amount of funds to be allocated to each center in the city. At the HN meeting, a motion was made and then withdrawn to have a representative from each of the local boards rather than from HN. The final decision was to have four representatives sent to the meeting.

In November, 1985, members were appointed to a joint committee with PHC to study a possible merger. Board members were concerned about potential loss of control over the individual centers and how a joint board with PHC could be formed that would allow input form the local boards. Meetings related to the merger continued for over a year without any issues being brought back to the board for a formal vote. Eventually the meetings stopped and the merger issue was dropped.

In the second year, 1985, lengthy discussions occurred related to the pharmacy contract and the patients' charges for prescriptions, feasibility of an HMO, distinguishing

between policy and procedure, introduction of a zero pay category, and evaluation of the director. During the first two years, voting issues raised at HN meetings were taken back to the local boards for their input before a vote was taken by the HN board. While this slowed down the decision making process, it allowed input from the local boards giving them a sense of maintaining control over events that affected the health centers.

Notwithstanding board members' involvement in what they perceived as policy decisions, in 1985, the DHHS regional director for community health centers challenged the relationship between HealthNet and Methodist Hospital as interfering with HealthNet being a full policy making board and suggested HealthNet end the contract with Methodist. The HealthNet Board Executive Committee, with the assistance of staff prepared a lengthy document to support HealthNet's claim to being a policy making board. This document and a site visit by DHHS representatives eventually resolved the issue. However, the role of HealthNet Board in policy making was not always as clearly resolved in practice.

In mid 1986, Dale Benson the executive director began attending HN board meetings on a regular basis, replacing the director of the chaplaincy program. Decisions continued to be primarily about financial issues, with other discussion related to increasing the number of patients receiving services through marketing and studying the

patient failure rate. Discussions were begun about the establishment of a foundation and developing other sources of funds.

Later that year when changes in fees were being made, a request by staff to increase the minimum fee from $1.90 to $3.00 failed and the 10% minimum charge reaffirmed unanimously. At a later meeting, the board formally requested that the HN financial committee be involved in the review and restructuring of the financial account system. Board members had begun to take more active roles in the decision making process.

In 1987 a financial crisis provided an opportunity for a high level of board involvement in decisions. The federal grant award for the year had been $140,00 less than requested. Halfway through the fiscal year, the Regional Office of DHHS informed the staff that the funds would be further reduced and HN was facing a deficit of $83,000 and would affect the delivery of health services. Joanne Martin, the board treasurer, provided needed leadership and with the assistance of Bill Sterling, the staff financial officer, they developed a list of potential cuts in programs. Landlords were asked to forego or reduce rents for a short time. While no programs were discontinued, some were reduced. Some staff voluntarily reduced their time and created major savings. The board insisted that a free pregnancy testing program be continued as it was the only

source of such services in the community. The board had played a greater role in the decisions related to the financial crisis than in earlier years.

By 1988, the HealthNet organization's budget had grown to over two million dollars. The eleven board members were hard pressed to address the issues associated with such a large organization. Although having only four committees, full participation (an unlikely event) by all members in the committees was needed to review alternatives and make wise decisions. The committee structure was unable to meet the demands place on it and staff were making decisions without full consideration and approval by the board. Some board members were extremely dissatisfied with this situation, and decisions being made without board approval and brought to the board after the fact began to generate dissent on the board. Although initially only a few of the Board members voted against staff decisions, dissension is now more common.[1] In one case, staff were placed in the awkward position of having to cancel a conference to which they had invited a speaker from Boston, when the board refused to approve the conference halfway into its planning.

Board non-approval of staff actions also took a toll on the Board. Some Board members considered the lack of support for staff actions as inappropriate. One Board

---

[1] need to address the conflict between bright, full of ideas staff and a Board that wants to follow the established process and review and approve what is going on.

member expressed dissatisfaction after the Board had failed to support a staff action "after they had put so much time into it" and later resigned (Egan).

Changes in the amount of power controlled by the board have occurred several times. From the initial notion of community control there was a move to greater programmatic control by the administrative staff. The elected leadership of the board during the last four years (1988-91) has challenged staff to be more candid with the board and has required that issues be brought to the board for approval.

Recently, the board has increased their control over policy issues, and this has not been resisted by administrative staff on some issues. On other issues, power struggles occur. At one point, most of the Board members were content to let "the staff carry the ball". As long as the members were notified by staff about their decisions they were willing to let them make the decisions. This has changed somewhat during the last three years. New Board members are taking a more aggressive approach, putting forth their own ideas and insisting on being heard. There are times now when staff have conceded to Board positions or they have worked together to obtain a compromise position that satisfies both groups.

Table E.I
Summary of population characteristics, 1980

Category	SouthEast/ Barrington	NearEastside	Marion County
Crowded Household	12%	10%	7%
No auto	18%	27%	12%
White Renters	33%	42%	39%
Median Family Income	$15,078	$13,525	$20,445
Percent Black	12%	7%	20%
Below Poverty Level	19%	21%	11%
High School Graduates	45%	47%	68%

Cell values are based on 1980 Census data compiled by the Community Service Council.

Table E.2
Home Ownership in 1990

Area	Percentage
SouthEast	61.5
Barrington	64.9
NearEast	50.0
Marion County	57.0
Indiana	70.2

Table E.3
Dependency Ratios

Area	Ratio
SouthEast	.70
Barrington	.75
NearEast	.66
Marion County	.59
Indiana	.63

CURRICULUM VITAE

NAME:

DIXIE WILES RAY
2030 East 12th Street

Indianapolis, IN 46201

(317) 638-9767

EDUCATION:

BA Sociology	Indiana University, 197 2 Indianapolis
MPA Public Affairs	Indiana University, 1977 Indianapolis
PhD Political Science	Indiana University, 1992 Bloomington

AREAS OF SPECIALIZATION

American Politics
    National Institutions Electoral
    Behavior and Linkages

Public Policy
    Policy Analysis
    Effects of Institutional Arrangements

ACADEMIC EXPERIENCE

1990 - Present Associate Professor, Department of
              Community Health Nursing, Indiana
              University School of Nursing, Indianapolis,
              IN

1983-1990   Assistant Professor, Department of
              Community Health Nursing, Indiana
              University School of Nursing, Indianapolis,
              IN

1977-1983   Lecturer, Department of Community Health
              Nursing, Indiana University School of
              Nursing, Indianapolis, IN

OTHER APPOINTMENTS

1989-1991   Program Associate, Healthy Cities Indiana
               (funded by the Kellogg Foundation)

1984-1987   Project Associate, DHHS Division of Nursing
               Grant No. D23 NU476, Health Policy and the
               Health of the Community

1984-1985   Co-Principal Investigator, Community
               Assessment Survey Project (Near Eastside
               Indianapolis, funded by People's Health
               Center)

1982-1983   Co-Principal Investigator, Community
               Assessment Research Project (Southeast
               Indianapolis, funded by Methodist Hospital)

1982-1984   Co-Program Director, DHHS Division of
               Nursing Grant No. D2 3 NU 00111, Expansion
               of Graduate Study in Community Health
               Nursing

1978-1984   Program Evaluator, DHHS Division of Nursing
               Grant No. D23 NU 00111, Expansion of
               Graduate Study in Community Health Nursing

1977-1979   Co-Project Director, DHEW Division of
               Nursing Grant No., D10 NU 25042, Region V
               Quality Assessment Study in Community
               Health Nursing

1976-1983   Program Evaluator, Department of Community
               Health Nursing, Indiana University School
               of Nursing

COURSES TAUGHT

Epidemiology
Community Health Assessment
Community Health Planning
Current Health Issues
Research Methods
Survey Research
Health and Society

PUBLICATIONS

Ray, D.W. & Rider, M. S. (1991). Impact of work upon
women's health. Journal of the Indiana Political Science
Association, (5, 3-11.

Flynn, B.C., Rider, M.S., & Ray, D.W. (1991). Healthy
Cities: The Indiana model of community development in
public health. Health Education Quarterly,18, 331-347.

Flynn, B.C. & Ray, D.W. (1987). Current perspectives in
quality assurance and community health nursing. Journal
of Community Health Nursing, 4., 187-197.

Ray, D.W. (1986). Epidemiology. In B. Logan and C.
Dawkins (Eds.), Family centered nursing in the community.
Menlo Park, CA: Addison Wesley.

Ray, D.W. & Flynn, B.C. (1985) . Graduate education in
public health nursing: Evaluation and recommendations.
Public Health Nursing, 2., 82-92.

Ray, D.W. & Flynn, B.C. (1980). Competition vs.
cooperation in community health nursing. Nursing Outlook,
28. 626-630.

Hawkins, J.L., Weisberg, C. & Ray, D.W. (1980). Spouse
differences in communication style: Preference,
perception and behavior. Journal of Marriage and the
Family, 42, 585-593.

Flynn, B.C. & Ray, D.W. (1978). Quality assurance in
community health nursing. Nursing Outlook, 20, 650-653.

Flynn, B.C., Gottschalk, J. Ray, D.W. & Selmanoff, E.D.
(1978). One master's curriculum in community health
nursing. Nursing Outlook,. 26, 633-637.

Hawkins, J.L., Weisberg, C. & Ray, D.W. (1977). Marital
communications style and social class. Journal of
Marriage and the Family, 39, 479-490.