

Health promotion through Neighborhood Health Centers: a tribute to George Rosen on the 20th anniversary of his death

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SUMMARY

George Rosen was not only one of the most noted medical historians in the United States, but also a pioneer in the scientific and practical establishment of public health. He promoted the socio-historical foundation of public health and emphasized the ambivalent role of the government between the creation of healthy living conditions and the control of individuals. Rosen was one of the first to point out the consequences of approaching social medicine exclusively from the perspective of modern bacteriology. The article shows that Rosen located elements of a democratic and holistic health system in his analysis of the Neighborhood Health Centers of the early 20th century. At the same time, he assessed the reasons for the demise of these efforts with the expansion of the medical-industrial complex after World War II. According to Rosen this development was mainly due to the lack of a solid financial plan that was feasible for the entire country. Until today the integra-

tion of medical care, social security and psychosocial counseling has not been re-established in this kind of community-oriented form. The Neighborhood Health Centers were mainly characterized by a democratic integration of the population to be served, by their intercultural approach and by the cooperation of people from a variety of professional backgrounds. They were thus an example of a cooperative, community-based health promotion in residential areas with a high degree of social problems. The aspects of integrative programs, proximity to residential areas and the participation of the population present key elements that could also prove significant for the future development of health promotion in today's health system. Reading George Rosen's work creates an awareness for the central questions concerning the definition of the 'New Public Health'.

Key words: George Rosen; health promotion; Neighborhood Health Centers

Health promotion is commonly acknowledged as the central idea of the 'New Public Health' (Frenk, 1993). The traditional public health paradigm that developed within the elimination of unsanitary living conditions in large industrial cities, today is understood as a great historical feat of health engineering. At the turn of the century, experts from a variety of different fields such as bacteriology, politics, administration and middle-class organizations worked together and succeeded in securing considerable financial investments for the improvement of health in large cities (Sreter, 1988; Labisch, 1992).

The idea of public health grew to be highly

regarded after the elimination of dangerous epidemics. It is evident that in today's wealthy nations completely different health issues require the employment of public health measures. The Norwegian professor of social medicine, Hjort, identifies significant changes in the spectrum of diseases and concludes that after the repression of infectious conditions, the main challenges for the health system, and for public health, are health issues such as mental diseases, psychosomatic disorders and related problems (such as musculoskeletal troubles), and the factuality of multiple diseases in many elderly people (Hjort, 1994). One of the central issues of stress-coping research

and the subsequently developed concept of salutogenesis (Antonovsky, 1987) has been the question of how people's psychosocial defence mechanisms could be used and strengthened in the prevention of diseases and the development of better coping strategies in situations of chronic illness. In this sense, health promotion is primarily interested in the improvement of the possibility of health and less in the reduction of risk factors, and it is thus not a medical but a societal and political task (Nutbeam *et al.*, 1990; von Troschke, 1993; Finebert *et al.*, 1994; Øvretveit, 1996).

The New Public Health is not to be understood as the exclusive responsibility of health system experts, but it is fundamentally dependent on an equal consideration of consumers' views. The truly new dimension of the New Public Health is the integration of the public in all health related concerns. However, a consideration of the public health pioneer and his report on Neighborhood Health Centers in the United States since the turn of the century (Rosen, 1971) raises the question of whether there are not underlying patterns of public health that have fallen victim to the triumphs of modern medicine and that need to be re-discovered in the context of 'New' public health. It is obvious that German history severed the lines of tradition which are, among other things, reflected in the works of George Rosen, who was extremely interested in German social history and who attempted to utilize the legacy of people from Virchow to Grotjahn and the establishment of national health insurance for a population-oriented health system in the USA.

Rosen's work acknowledges the fact that as early as the 18th century social medicine played with the idea of forcing political measures on the state by offering analyses of the social dimensions of illnesses. The idea of monitoring the health of the population and of enforcing healthy ways of life existed early on. With the Bourgeois Revolution the social dimensions of health and illness were newly thematized and the causality between social class and mortality rates moved to the center of social medicine. Linked to this development were emancipatory ideas: socially disadvantaged groups began to claim their rights on the basis of the idea of social equality and justice. Rosen pointed out at an early stage that bacteriology endangered the socio-political discourse on equal opportunity because the diagnostics and control of micro-organisms seemed to become the sole guarantor of future progress.

Rosen also predicted that social hygiene, especially its more emancipatory forms, was going to be under increasing pressure from the rising popularity of 'social Darwinism' (Rosen, 1963). His main interest was aimed at the development of effective prevention in a cooperative system that offered population-oriented health services.

In his article about Neighborhood Health Centers, Rosen characterized the structure and function of these institutions as a response to the needs of the poor sections of the population that have not been reached by the medical system. They provide, as Lisbeth Bamberger (1966) pointed out:

[a] one-door facility, in which virtually all ambulatory health services are available; close coordination with other community resources; professional staff of high quality; and intensive participation by and involvement of the population to be served.

As a son of immigrants himself, it is not surprising that Rosen was sensitive to the health issues surrounding the great waves of migration between 1860 and 1910, which meant tight living spaces, social segregation and dependency on one's own ethnic community for the mostly poor immigrants. Since the end of the 19th century, and increasingly between 1910 and 1920, cities and communities responded to the accumulation of these 'risk factors' with classic concepts of local hygiene, such as the improvement of living conditions and efficient garbage removal, but also with specific counseling programs for adolescents with cocaine addiction, as in Chicago. Cities increasingly participated in the development of health centers with comprehensive examination and counseling programs. From Rosen's perspective, these programs put special emphasis on the following five aspects:

- (i) proximity to residential areas and good knowledge of the neighborhood;
- (ii) participation of the population in the concept of a democratic community;
- (iii) consideration of language barriers;
- (iv) combination of health-related and social counseling;
- (v) focus on specific problems in regard to prevention, counseling and support.

The programs usually included: pregnancy supervision, health in schools, tuberculosis, venereal diseases, dental care and welfare. For Manhattan, Rosen describes the make-up of the teams for a camp of 25 000 people as follows: one

medical officer, one medical inspector, three nurses, one doctor's assistant, one food inspector and one hygiene inspector—most of them worked part-time. In 1920, there were about 72 centers in the USA that met these requirements. About half of them were run by the local administrations; the other half were funded privately or operated semi-privately. Statistics show that in 1930 there were 1511 health centers of this kind. Rosen, however, bemoans the fact that after 1920 a number of different organizations and institutions used the good name of these centers for themselves, without meeting the essential requirement of an integrative approach. The health center movement started losing its momentum before the World War II, and in retrospect Rosen identifies the following reasons:

- (i) The inability to find a stable financial basis made it difficult to support the potential for self-help in the living quarters.
- (ii) Medical progress increasingly supported the concept of individualized medicine.
- (iii) Second and third generation immigrants moved up in the social hierarchy and were increasingly attracted to the idea of private medical care.
- (iv) The trend toward specialization in hospitals and other medical institutions made the concept of integration seem too weak; in addition, the often poor financial situation of the health centers resulted in their decreasing appeal.
- (v) The health centers were accused of treating people who were not in need.
- (vi) The increasing specialization in the medical field and the development of independent social service organizations resulted in the disintegration of medical and social programs.
- (vii) Under the influence of psychoanalysis, social work was increasingly defined as a therapeutic service for specific problems.

Rosen finishes with a brief consideration of post-war health centers which again felt responsible for the extremely poor and did not claim any broad appeal. Without actually mentioning it, his final question aims at the US medical system's general need for reform:

Should neighborhood centers remain purely local, or should they become part of the larger system of health care toward which we appear to be moving. Should

they become part of a national health insurance system and of a larger health-care delivery system?

In view of the current debate on the structural reform of the German health system (Schmacke, 1997)—not to mention the failure of the Clinton plan—the question arises whether Rosen did not emphasize fundamental aspects of the integrative health system when he pointed to the concept of the Neighborhood Health Center: familiarity with people's social and economic conditions permits health promotion in a way in which the principles of prevention and care reach the greatest possible number of people, and in which the need is seen for people's integration in the development of their own specific interests. Both Fee and Morman (Rosen, 1993) point out in their introduction that Rosen was concerned with and highly skeptical of delegating too much responsibility to health experts. This is maybe what differentiates Rosen's concepts from those following the Ottawa Charter of 1986. His appeal to *the state* to guarantee health through education, housing policy, maintenance of industrial health and safety standards, food inspection and good medical care may, however, be the flip-side of the coin which, in times of a de-regulation euphoria, we will have to observe carefully. And, finally, an analysis of the health center movement helps us see our own institutions more clearly and recognize that we need to preserve the tried and tested elements of health maintenance, while also considering the still unresolved issues in the wake of a changed spectrum of illnesses.

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