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UTILIZATION AND VIEWS OF AVAILABLE HEALTH CARE AMONG RESIDENTS IN THREE POVERTY NEIGHBORHOODS IN PITTSBURGH, PENNSYLVANIA

By

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Submitted to the Graduate Faculty in the School of Social Work in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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1970

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a wife has the skill, ability, and willingness to also contribute directly to the completion of a research endeavor one is fortunate indeed. Thus, to Helen, whose language and editing skills were as valuable as her always astute criticism, the author is greatly indebted.

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CHAPTER I

INTRODUCTION AND REVIEW OF THE LITERATURE

Introduction

Health care in the United States is a burgeoning industry with expenditures of $63 billion in 1969, according to a recent issue of Fortune, and should growth continue at the current rate, expenditures will reach $200 billion by the early 1980's.[1] The $63 billion figure represents a fivefold increase in outlay in less than two decades. This same period of time has been noted for a dramatic increase in medical knowledge and technology which has combined to eliminate or to bring under controllable proportions many of the dread diseases which have plagued society for centuries. New miracle drugs and advanced surgical procedures using sophisticated equipment are saving and prolonging life at a galloping rate. In the United States today there is medical knowledge and technology enough to compete with the best in the world. Yet, there is growing consternation among consumers and providers of health care alike over our health care system, or nonsystem as it is often referred to, and its capability of living up to its promise under its

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[1] "Our Ailing Medical System," Fortune (January, 1970), p. 81.

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current organization. For, despite the massive expenditure of funds, the increased knowledge, and the sophisticated technology, there is a gap between what we know in terms of health care and what we are in reality providing.

Publicity attending dramatic developments in the health care field in the last few years has caused the emergence of rising expectations that quality care would be widely available. However, skyrocketing costs and an inadequate delivery system have given rise to public awareness of the inequities that prevail in a situation that experts agree is one of chaos bordering on national disaster.

The chaotic state of our health care system affects rich and poor alike. Time, in an article on medicine, pointed out that only 25 percent of the population can be considered to obtain a "fair shake" for its money, while for 50 percent medical care is only passable but not what it could or should be.[2] However, for the remaining 25 percent, care is either inexcusably bad or nonexistent. In other words, having a substantial income is no guarantee of availability of quality care nor does being poor necessarily militate against getting excellent care. Nevertheless, on the average and by all current measures, health care, for the poor, is still on a lower level than for the rest of population, and health care resources are utilized less by

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[2]"The Plight of the U. S. Patient," Time (February 21, 1969), p. 53.

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the poor than by the upper and middle classes.[3] Findings of a relationship between poverty and ill health have been made consistently for centuries. Only the definitions of poverty and health have changed to meet the changing conditions and aspirations of society that technological and economic advancement brought about.[4]

Review of the Literature

Health Deficit Among the Poor

The literature, both popular and professional, is replete with evidence of the excessive burden of illness borne by the poor in contrast to the more advantaged classes. Twelve nations of the western world have infant mortality rates lower than that of the United States, largely because excessively high rates among our poor keep down our national average.[5] For essentially the same reason, the United States ranks behind most of these same countries in maternal mortality and deaths due to heart-artery diseases and cirrhosis of the liver.[6] As Roemer and Kisch point out,

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[3]Lola M. Irelan, "Health Practices of the Poor," in Lola M. Irelan (ed.), Low Income Life Styles (Washington: Government Printing Office, 1966), p. 51.

[4]Patricia A. Leo and George Rosen, "A Bookshelf on Poverty and Health," American Journal of Public Health, LIX, No. 4 (April, 1969), 591-593.

[5]"Plight of U.S. Patient," Time, op. cit., p. 53.

[6]Ibid.

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although the greatest class differential in mortality rate is found among the young, there is in fact a higher mortality rate among the poor in all age groups.[7]

In a systematic survey of existing empirical data comparing physical health of the poor with that of the rest of the population, Monroe Lerner concludes:

> Clearly the poverty population is considerably less healthy than the rest of the population of this country. It still experiences substantially higher rates of overall mortality (all ages and by age, and especially from communicable diseases), infant mortality, and severe illness. Its level of dental morbidity is higher and its need for dental care much greater.[8]

Conclusions such as the above are reached consistently throughout the literature. Much of the data upon which they are based are derived from the National Health Survey of the National Center for Health Statistics,[9] which according to Lerner are by far the best data available despite some important shortcomings.[10] For example, Roemer

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[7]Milton I. Roemer and Arnold I. Kisch, "Health, Poverty, and the Medical Mainstream," in Bloomberg and Schmandt (eds.), Power, Poverty, and Urban Policy (Urban Affairs Annual Review Vol. 2; Beverly Hills, California: Sage publications, 1968), p. 182.

[8]Monroe Lerner, "Social Differences in Physical Health," in Kosa, Antonovsky, and Zola (eds.), Poverty and Health: A Sociological Analysis (Cambridge, Mass.: Harvard University Press, 1969), p. 111.

[9]See for example National Center for Health Statistics, "Medical Care, Health Status, and Family Income," Series 10, No. 9 (U.S. Department of Health, Education, and Welfare, May, 1964).

[10]Lerner, op. cit., p. 101.

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and Kisch, in discussing morbidity differentials between the poor and the nonpoor based upon the 1962-1963 National Health Survey, indicate that those suffering from chronic activity-limiting conditions are nearly four times more likely to be from families with annual income under $2,000 than from families with annual incomes of over $7,000 (28.6 to 7.9 percent respectively).[11] Similarly, Richardson, in analyzing the 1965-1966 National Health Survey data in terms of days lost from activity, restricted activity days, bed disability days, and work-loss days--all accepted indices of level of illness--found that the differential between the poor and nonpoor was substantial.[12] Table 1, constructed from a report appearing in Sources, a Blue Cross publication, illustrates in summary form the excessive burden of illness borne by the poor as contrasted to the nonpoor. It compares the morbidity rate of two income groups in six leading diagnostic categories of disabling conditions.[13]

Utilization of Health Care Among the Poor

There is no indication in the foregoing as to which is considered cause and which effect in the relationship

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[11]Roemer and Kisch, op. cit., p. 182.

[12]William C. Richardson, "Poverty, Illness, and Use of Health Services in the United States," Hospitals (Journal of the American Hospital Assn.) (July 1, 1969), p. 36.

[13]"Health Services for the Poor," Sources, I (1969), 52.

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TABLE 1

MAJOR ACTIVITY LIMITING CONDITIONS BY INCOME
(rate computed per 1,000 population)

Major Activity Limiting Condition	Income Level	
	$7,000 and up per Annum	Less than $2,000 per Annum
Heart Condition	11.9	53.8
Mental & Nervous Disorder	4.2	26.4
Arthritis & Rheumatism	8.7	59.3
High Blood Pressure	3.9	23.8
Orthopedic Impairment	14.9	54.4
Visual Impairment	2.7	23.4

SOURCE: Adapted to tabular form from data appearing in the text of a report, "Health Services for the Poor," Sources, I (1969), 52.

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between poverty and ill health. It is likely that both are so thoroughly intertwined that they interact to form a cycle of poverty and ill health where both may be either cause or effect. However, whether poverty causes ill health or whether ill health causes poverty, or whether both are true, the end result is such that the need for health care is greater among the poorer segment of our population than among the population at large. Nevertheless, the overwhelming weight of evidence indicates that the poor utilize medical services either to the same extent as or much less frequently than others and that those services utilized are of lesser quality than those used by the rest of the population.[14] For example, in a study of health services utilization among welfare families in New York City, Pomeroy, Lejeune, and Podell found that when compared to national samples there was little class variation, if any, with respect to aggregate utilization of medical resources.[15] However, they quickly go on to state that before one regards social class as irrelevant to utilization, it is important to judge utilization of any service relative to need, and since the health care needs of the poor are greater than for the rest of the population, they should be using more

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[14] Roemer and Kisch, op. cit., p. 189.

[15] Richard Pomeroy, Robert Lejeune, and Lawrence Podell, Studies in the Use of Health Services by Families on Welfare: Utilization by Publicly Assisted Families (New York: Center for the Study of Urban Problems, 1969), p. 18.

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medical services than, and not the same amount as, the general population.[16] Analyzing both published and unpublished data from the National Center for Health Statistics, Richardson found that in 1964 only 64 percent of the lowest income people (under $3,000 per annum) had physician visits against 73 percent for the highest income group ($10,000 and more per annum), and those with low incomes were three times as likely as those with high incomes not to have seen a physician within the previous five years, 9 percent and 3 percent respectively.[17]

Another measure often employed to assess utilization of health services is whether or not families have a doctor whom they consider their family doctor and to whom they usually turn in time of medical need. In this connection, Julius Roth, quoting figures from the results of a study concerning types of families that use an emergency clinic, conducted by Joel Alpert et al. and published in Medical Care in 1969, indicates that only 16 percent of families on welfare had a doctor while 85 percent of families having annual incomes of more than $10,000 had one. He notes two income breaking points relative to having a family doctor: a minority of families with incomes below $4,500 have a usual physician, whereas almost all families with incomes

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[16] Ibid., pp. 18-19.

[17] Richardson, op. cit., p. 37.

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above $10,000 have such a doctor.[18]

Quality of Health Care for the Poor

As noted above, not only do the poor utilize fewer medical resources, but also those that they do use are likely to be of lesser quality in terms of the prevailing value placed on fee-for-service and the ethos of the doctor-patient relationship.[19] Many of the visits to doctors by the poor are of a different type than those made by the nonpoor. It is commonly argued that two kinds of medical service exist in this country: that of the middle-income class which uses private doctors, and that of the low-income class which uses the public clinics.[20] Although most visits to a doctor take place in a private physician's office, a higher proportion of the poor is more likely to have the locus of doctor contact in a clinic or emergency room. Those private physicians who are seen by the poor are more likely to be general practitioners rather than specialists. Lower-income people get fewer prescribed drugs, rely more heavily on over-the-counter patent medicine, and have more nonphysician contacts. On the average, the poor are hospitalized more frequently and have longer hospital stays than

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[18] Julius Roth, "The Treatment of the Sick," in Kosa, Antonovsky, and Zola (eds.), Poverty and Health: A Sociological Analysis (Cambridge, Mass.: Harvard University Press, 1969), p. 217.

[19] Ibid., pp. 222-229.

[20] Ibid., p. 220.

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the nonpoor. Thus, two-thirds of welfare medical expenditures go for hospital care of indigents and only one-third for outpatient treatment. For self-supporting persons the reverse is true.[21]

Preventive Medical Care Among the Poor

From the point of view of preventive medical care as reflected by routine physical checkups and immunizations, the poor also come off badly relative to the more advantaged classes. Cornely and Bigman, in a study of low-income groups in Washington, D. C., found that although a large majority of respondents felt it was important to have physical checkups, only a minority actually had had one during the study period.[22] Similar findings were made with respect to immunizations and preventive diagnostic procedures such as blood test, urinalysis, and x-ray.[23] In a study of socioeconomic and health data from Pittsburgh's eight poverty neighborhoods, the Allegheny County Health Department found that (except for smallpox vaccinations where 70.6 percent of this population were immunized) only a small minority of their residents had been immunized or participated

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[21] Roemer and Kisch, op. cit., pp. 189-193.

[22] Paul P. Cornely and Stanley K. Bigman, Cultural Considerations in Changing Health Attitudes (Washington, D.C.: Howard University, December, 1961), pp. 74-82. (Mimeographed.)

[23] Ibid., pp. 101-110.

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in preventive diagnostic procedures.[24] National figures present a similar picture indicating that only 10.8 percent of medical visits by poor families are for prevention contrasted to 17.5 percent for high income families.[25]

Dental Care Among the Poor

Dental care for most Americans is, on the whole, on a much lower priority than is medical care. Yet, in the area of dental care the differential between the poor and nonpoor is greater than that observed in connection with medical services.[26] Differences here, as with medical care, exist in quantitative and qualitative dimensions. National Health Survey figures for 1963-1964 indicated that only 23 percent of the lowest income group (under $2,000 per annum) visited a dentist opposed to 64 percent of such visits among the highest income group ($10,000 and over per annum) with steadily increasing percentages of dental visits from lowest to highest income groups.[27] Also whereas 22 percent of the low-income people had never seen a dentist,

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[24]Allegheny County Health Department Bureau of Health Referral Services, Socio-Economic and Health Data Obtained from Families Interviewed by OEO Personnel of Pittsburgh, Pa. OEO Target Neighborhoods (Pittsburgh, Pa.: Allegheny County Health Department, March 15, 1969), p. 9. (Mimeographed.)

[25]Richardson, op. cit., p. 39.

[26]Edward A. Suchman and A. Allen Rothman, "The Utilization of Dental Services," Millbank Memorial Fund Quarterly, XLVII, No. 1 (January, 1969), Part 2, p. 56.

[27]Richardson, op. cit., p. 39.

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this was true for only 7 percent of the high-income group.[28] When low-income people do see a dentist, such visits are more likely to be for extractions rather than for cleaning and filling teeth.[29]

Factors in Addition to Income Associated with Utilization

The consistency of the findings of a relationship between income and health and utilization of health care services leaves little doubt that lack of money militates against the maintenance of good health because it inhibits adequate utilization of the required preventive and ameliorative health care resources. Yet lack of funds alone does not fully account for the low levels of health care utilization. For despite numerous public and private low cost or no cost health care programs aimed specifically at the poor, their utilization continues at a low level while mortality and morbidity rates remain higher for them than for the rest of the population. It has been found, for example, that age, education, and race are also independently related to utilization of health care services.

Age. Utilization of health services generally increases with age primarily because the need for health care is greater due to increasing incidence of illness

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[28] Ibid.

[29] Roemer and Kisch, op. cit., p. 170.

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with age.[30] However, old age for two-fifths of such households is accompanied by poverty level incomes.[31] Although the aged poor utilize more health services than their younger counterparts, there remains a gap between the poor and nonpoor in that age category albeit at a lesser differential.[32]

Education. Similarly we find better health and increased utilization among the better educated. This is due primarily to the more sophisticated knowledge of the meaning of symptoms and to the greater familiarity with available health care resources among the better educated.[33] This, in turn, leads to earlier use, preventive use, and greater use of existing resources.[34] At the same time better education generally contributes to higher income which allows the use of more specialized type of care. The poor being characteristically of lower educational attainment are thus in double jeopardy--even when cost of service

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[30]For references concerning age and health and health care utilization see: E. Confrey and M. Goldstein, "The Health Status of Aging People" in Clark Tibbits (ed.), Handbook of Social Gerontology (Chicago: University of Chicago Press, 1960), pp. 165-207. P. Lawrence, "Methods in the National Health Survey: Age Patterns in Morbidity and Medical Care," in J. Birren (ed.), Relations of Development and Aging (Springfield: Charles C. Thomas Press, 1964), pp. 79-94.

[31]Mollie Orshansky, "The Poverty Roster: A Head and Heart Count," Sources, I (1969), 10.

[32]Roemer and Kisch, op. cit., p. 189.

[33]Lola M. Irelan, op. cit., pp. 54-55.

[34]Cornely and Bigman, op. cit., p. 63.

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is not a factor militating against usage of health care facilities, because of their lower level of education they are less likely to recognize important symptoms of illness and are less likely to be aware of professional resources to which to turn for help.

Race. The situation with respect to the relationship between race, health, and utilization of health care is among the most documented phenomena in the study of health related empirical data. The weight of findings shows clearly that by all measures of health and utilization and holding all socioeconomic and other demographic factors constant non-whites, particularly, but by no means exclusively, blacks, come off worse than their white counterparts in all categories. The National Urban League in 1965 published a report on health care and the Negro which was submitted by its Subcommittee on Health Needs and Resources. This report presents the Subcommittee's analysis and interpretation of available relevant information systemically compiled from a multitude of disparate sources.[35] In his foreword to this document, Whitney M. Young, Jr., stated:

> The undeniable fact is: Infant or adult, man or woman, northerner or southerner, the Negro is substantially less healthy than the white.
>
> Poor health along with all the other disadvantages imposed upon him, has become the Negro's lot. Perhaps

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[35]National Urban League, Health Care and the Negro Population (New York: National Urban League, 1965), pp. 1-34.

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> even worse is the fact that Negroes, who need so much more in the way of health care, get so much less than white people. And what they get is less good.[36]

The report itself, although brief, is laden with information reflecting the disparity between the races in the sphere of health and health care. The ensuing discussion relies heavily upon some of the findings of the National Urban League's Subcommittee on Health Needs and Resources as contained in this report.

The maternal death rate for Negro women in this country is four times that of white women. Similarly, the mortality rate of Negro children within the first year of life is 41 per thousand contrasted with 22 per thousand for white children--twice as high. A 1964 Chicago study of mortality in poverty and nonpoverty areas showed that for both areas combined the mortality rate for nonwhite infants in the first year was 14.3 per thousand live births compared to a rate of 5.6 for whites; two and a half times greater.[37]

This discrepancy continues at all age levels. For example, of every thousand white persons who survive into their late forties, five will die in the next year, while for Negroes in the same age category ten will die. In general, life expectancy for the Negro at infancy is seven

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[36] Ibid., pp. 1-2.

[37] Monroe Lerner, op. cit., p. 96.

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years shorter than for white infants and at all ages proportionately more Negroes than whites die.

The morbidity picture as it reflects race differentials is equally bleak. The National Urban League's Subcommittee on Health Needs and Resources found that:

> The Negro in comparison to the white, has more diseases and disabilities, one-third more days when he is unable to function at full physical capacity, is sick enough to require bed rest on twice as many days and loses one and one-half times more days from work because of diseases and disability.[38]

In a health survey in a low-income Negro area of Atlanta, Georgia in 1968, Richardson found that regardless of income this population reported a higher level of illness than the national average.[39]

Many of the race differentials in morbidity are reduced when considering only the poor. This is indicative of the major contribution of poverty alone to high morbidity rates. Yet, in many areas of health, even among the poor, the incidence rates of certain disability categories is much higher for Negroes than for whites. For example, Sussman mentions a study of disability in Maryland which found that, within the poverty group, Negroes had seven times as much blindness and twice as much diabetes as the poor whites.[40] The situation with respect to dental care

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[38]National Urban League, op. cit., p. 6.

[39]Richardson, op. cit., p. 38.

[40]Marvin B. Sussman, "Readjustment and Rehabilitation of Patients," in Kosa, Antonovsky, and Zola (eds.), Poverty

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is essentially similar in that it is lowest for Negroes and Puerto Ricans, regardless of socioeconomic status.[41]

Utilization of health care services by blacks is as disproportionately low as their health care needs are great. From national data for 1966-1967, Richardson indicates that whereas white children under age 15 in families below $5,000 averaged 3.3 physician visits per year, nonwhite children in the same category averaged only 1.9 such visits. This is compared with a national overall average of 4.1 visits in that age and income category. Race differentials are found in each age and income category.[42] Similarly, Negroes at any income or occupational level are less likely to have a continuing relationship with a doctor than whites in those same categories.[43]

The National Urban League found similar racial disparities in other measures of health care utilization. For example, their report states that in an average group of 100 white people, about 12 will have a short hospital stay during the year whereas for Negroes the average will be only 9.[44] An exception to this is the rate of Negro

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and Health: A Sociological Analysis (Cambridge, Mass.: Harvard University Press, 1969), p. 246.

[41] Suchman and Rothman, op. cit., p. 56.

[42] Richardson, op. cit., p. 38.

[43] Julius Roth, op. cit., p. 217.

[44] National Urban League, op. cit., p. 9.

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hospitalizations for severe psychiatric disorders which have increased at a more rapid pace than that of whites and remains at a higher rate.[45] Further, the hospitalization rate of nonwhites, 92 percent of whom are Negroes, is 20 percent less than for the entire population while their use of clinics is double the rate of whites.[46]

To recapitulate: health care as it is currently organized in the United States affects both rich and poor alike in its fragmentation, its unequal distribution, and its rising cost. Within that context, however, the poor are by far the greatest losers when existing health and health care are examined in relative terms. They are relatively sicker and relatively more disabled but utilize relatively fewer preventive and ameliorative medical services than those in better circumstances. Nonwhites, as a group--the majority of whom are black--fare even less well than whites in the same categories employing the same measures. The health care system as it exists today for the poor may be summarized in the words of Dean Ebert of the Harvard Medical School:

> "Medicine until now, in this century, has been a middle class institution. You practice on poor people, but you are really going to take care of the

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[45] Marc Fried, "Social Differences in Mental Health," in Kosa, Antonovsky, and Zola (eds.), Poverty and Health: A Sociological Analysis (Cambridge, Mass.: Harvard University Press, 1969), pp. 135-136.

[46] National Urban League, op. cit., p. 10.

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> middle class. All of medicine is essentially this way. At every level the poor come off badly. They are used for teaching purposes, they have more serious disease, their mortality rates are higher at all ages, they have more serious psychological disorders, their medical care is fragmented and discontinuous, they are powerless in the system . . . ."[47]

How the Poor View Health and Health Care

In spite of what is known by a wide variety of experts relative to the relationship of poverty, ill health, and low consumership of health care as reflected in the foregoing discussion, surprisingly little is known about how the poor themselves view their health and available health care. In an editorial by Walter J. McNerney, president of the Blue Cross Association, he states:

> Little is known about how the poor themselves regard the state of their health or how they evaluate the health care programs available to them and other Americans.[48]

Yet, at a time when organizers, planners, and citizen activists are clamoring for more consumer participation and representation in those decisions which affect their lives, if health programs are to be relevant to their consumers' needs and wishes, to be successfully implemented, and to be adequately utilized, it is essential that views of consumers and potential consumers of health care be

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[47] Michael G. Michaelson, "Medical Students: Healers Become Activists," Saturday Review (August 16, 1969), p. 54.

[48] Sources, op. cit., p. 1.

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explored. Also, there is reason to believe that the poor do not always share the pessimistic views of experts regarding the adequacy of service in spite of the overwhelming evidence. For example, a study of social and economic conditions and programs in Pittsburgh's eight target poverty neighborhoods was carried out during 1967-1968 by Community Action Pittsburgh, Inc. (the city's anti-poverty agency). A summary of their findings concerning neighborhood ratings of several services concluded that:

> In the eight poverty areas, professional planners and groups of activist citizens were highly critical of schools, housing, police, and other public services. Yet, in every one of these areas, over half of the people questioned rated all these conditions as satisfactory. No service or condition was considered unsatisfactory by as many as one-third of the respondents.[49]

Despite the paucity of information with respect to how the poor view their health and available health services, it is likely that the positive ratings for other services found extant among the poor by Community Action Pittsburgh might also hold up when their views of health and available health care are explored. For example, one effort to explore this issue has been made by the Blue Cross Association. The Louis Harris Organization was commissioned by the Blue Cross Association to conduct a survey of a

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[49]Community Action Pittsburgh, Inc., Target Neighborhood Report: Social and Economic Conditions and Programs (Pittsburgh: Community Action Pittsburgh, Inc. 1969), p. V1. (Mimeographed.)

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national sample to explore the attitudes of the poor about a variety of health related subjects. The results of this study indicate that nationally among the lower income groups, under $5,000 per annum, 61 percent felt that their health is the same as or better than that of previous generations, while 39 percent felt it to be worse. However, among specific poverty groups, i.e., blacks and Appalachian whites, the results were 49 percent and 37 percent respectively who felt their health to be the same as or better than that of previous generations, whereas 51 percent and 63 percent, respectively, felt it to be worse. For the more affluent, i.e., those in yearly income categories of $5,000-$9,999, and $10,000 and over, the percentages were 75 percent in each group who felt they are in the same or better health than others in previous generations.[50]

With respect to ratings of available medical and physician services, the results of the Harris survey are found in Table 2. From this table it is clear that the majority of the poor give a positive rating to each category of available medical or doctor's service, and in most categories the percentage of poor giving favorable ratings differs little from the proportion of the more affluent who give such ratings.[51]

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[50]Louis Harris, "Living Sick! How the Poor View Their Health," in Sources, op. cit., p. 23.

[51]Ibid., p. 29.

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TABLE 2

RATINGS OF MEDICAL AND PHYSICIAN SERVICES

Rate Positive	Total Public %	Affluent %	Poor %
Private specialist	93	96	95
Veterans' hospital	88	86	89
Clinic at major hospital	85	85	83
Neighborhood doctor	76	84	62
Clinic where you pay	68	58	70
Group health center	67	65	64
Medical insurance doctor	62	52	59
Union Medical Center	53	57	74

SOURCE: Louis Harris, "Living Sick! How the Poor View Their Health," Sources, I (1969), 29.

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The Louis Harris survey elicited comparative ratings concerning the views of the poor and nonpoor related to the differential in care between private physicians and clinics. The results compared the views of the affluent with those of poverty blacks. Since, as was discussed earlier, blacks are more prone to clinic use and clinics are generally considered to be of inferior quality, one would expect a high proportion of blacks to be unfavorably disposed to clinic care. Nevertheless, the findings showed that 58 percent of poor blacks rated clinics as good as or better than care by a private doctor compared with 74 percent of the affluent who so rated.[52] When asked which health care service gives the best care, the results were as shown in Table 3. Here again it can be seen that among the poor, hospital clinic care is rated best in quality by 27 percent, second only to private specialist.

The Study Problem

Inherent in the above findings are important implications for efforts to plan, organize and implement programs aimed at equalizing the distribution and delivery of health services to the poor. This is especially true if we are to pay more than lip service to the need for involvement of those to be served in the decision-making processes which impinge directly upon their lives. That such involvement

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[52] Ibid., p. 29.

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TABLE 3

WHICH GIVES BEST CARE?

Give Best Care	Total Public %	Poor %
Private specialist	43	37
Neighborhood doctor	21	10
Clinic at major hospital	17	27
Veterans' hospital	10	14
Clinic where you pay	2	3
Group health center	1	1
Medical insurance doctor	1	2
Union Medical Center	1	3
Not sure	4	3

SOURCE: Louis Harris, "Living Sick! How the Poor View Their Health," Sources, I (1969), 30.

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is important to the success of programs is a widely accepted concept shared by such national planning bodies as the Public Health Service[53] and the Office of Economic Opportunity[54] and the local Hospital Planning Association of Allegheny County.[55]

Under the current organization of health care in the United States and in light of the importance placed upon grass roots level planning, many special health care programs are conceived on a local level with specific target populations in mind. Funding for their implementation is sought wherever feasible--much of it from federal resources. In view of these factors, much information needs to be obtained locally from those whom the service is to help with specific reference to their uniqueness as individuals and as a community. There is a danger in applying to specific communities that which we know to be true in general from national figures or from studies of other localities even when on the surface such communities bear similar socioeconomic and demographic characteristics. As with people, individual

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[53]U.S. Department of Health, Education, and Welfare, Public Health Service, "Comprehensive Health Services Projects." (Guidelines for Projects under Section 314(a) of the Public Health Services Act; Washington: Public Health Service, February, 1969), p. 3.

[54]Lee and Rosen, op. cit., p. 594.

[55]Hospital Planning Association of Allegheny County, Hospital Service Areas in Allegheny County (Pittsburgh: Hospital Planning Association of Allegheny County, November, 1967 [reprinted]), Appendixes A & B.

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communities differ considerably from one another, and in the aggregation of data much of this individual character can be lost. For example, in Richardson's study of a low-income black community of Atlanta, Georgia cited earlier, it was found that despite the fact its population was younger than average, the reported chronic activity limiting illness rate was 50 percent higher than for the nation as a whole.[56] Similarly, Cornely and Bigman concluded that:

> . . . families living in low-income areas cannot be considered as a homogeneous group to which uniform approaches and procedures can be applied. It is fashionable these days to talk rather loosely and glibly about the hard-to-reach segment of the population and quite often this is synonymous with people of low-income areas. There is a danger that if this frame of mind persists among public health people, programs developed for such groups will end in failure.[57]

David Mechanic issues a similar note of caution:

> We fail to appreciate the diversity of thought and action in communities which we regard as constituting part of the same culture--understanding such subcultural differences is essential if one is to make any sense of social processes.[58]

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[56] Richardson, op. cit., p. 38.

[57] Cornely and Bigman, op. cit., p. 167.

[58] David Mechanic, Medical Sociology (New York: The Free Press, 1968), pp. 28-29.

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CHAPTER II

STUDY OBJECTIVES AND METHOD

In the previous chapter it was indicated that the chaotic state of our current system of health care organization affects both rich and poor alike. Both groups are unable to secure the benefits of the advanced medical technology which we possess but have yet to make widely available. The need for a major reorganization of the entire health care field is obvious. Nonetheless, such a reorganization is not likely to come about in the near future, and the problems resulting from our current system will continue to be handled in a characteristically crisis-oriented categorical fashion. Notwithstanding, in the absence of a complete reorganization of the present health care system, many efforts have been undertaken within the framework of the existing organization to improve the quantity and quality of health care available to the poor.

One such effort was undertaken by Presbyterian-University Hospital in Pittsburgh with the inception of its Health Care Expediter Program in 1967. This program, of which the author is currently the director, has provided the auspices under which this study has been conducted. Thus, a brief description of the Health Care Expediter Program: its history, objectives, and major functions is

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in order at this point before discussing the study objectives and methodology.

The Study Setting

The Health Care Expediter Program at Presbyterian-University Hospital was conceived by the hospital in 1965 and implemented in October, 1967 with the hiring of two indigenous nonprofessional health care expediters. As conceived, the program was designed for the purpose of meeting the health care needs of residents in poverty neighborhoods in Pittsburgh with special emphasis on two of eight neighborhoods as designated by Community Action Pittsburgh, Inc., Pittsburgh's anti-poverty agency. The two prime target areas for the initial program, the Hill District and Hazelwood, are located within the primary service area of the hospital. In April, 1969, a grant to expand the program was received from the Public Health Service under Section 314(e) of the Public Health Service Act. Expansion included the addition of a third target neighborhood, South Oakland, thereby covering all poverty neighborhoods in the hospital's primary service area for Health Care Expediter service. In addition to the inclusion of South Oakland for Expediter activities, expansion permitted the hiring of three more health care expediters, a project director, and a project secretary, thereby creating a new department in the hospital's table of organization

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which was responsible directly to administration.

The concept underlying the program's implementation is that one of the characteristics of the poor is their isolation from the mainstream of society. Such isolation has created a situation wherein existing health care facilities have failed to reach many segments of our low-income population. Thus, a reaching out approach is necessary to bring residents in the poverty neighborhoods into a system of quality medical care.

Toward this end, the program's three major objectives, set forth in terms intended to allow maximum flexibility of operation and activity, are:

1. To improve the health care of the target populations by encouraging use of medical care resources for preventive and therapeutic purposes.

2. To determine obstacles which impede effective use by residents of available medical care.

3. To initiate action to remove or reduce barriers which hamper receipt of quality medical care.

To achieve these objectives, the program was to determine areas of health neglect and to initiate those services and foster those conditions which would encourage residents in the target neighborhoods to make more extensive and effective use of the medical facilities and services available in the hospital and its outpatient department, Falk Clinic.

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Specifically, the health care expediters reach out into their neighborhoods to promote a relationship between them and the hospital which is meant to encourage freer use of available medical facilities. They interpret to their communities what health care is available to them, and interpret to the hospital how best to provide its service. In essence, theirs is a bridging function which eases communication between the hospital and its consumer constituency in the poverty neighborhoods. The expediter therefore is a liaison agent of the hospital whose primary responsibility is to represent the health care interests of her community to the hospital's administration. In this role the expediters participate in evaluating information regarding their community's health care needs obtained as a result of their reaching-out activities. Such information then serves as a factual basis from which changes in health care programming can be made. Also, the expediters, as they move through their neighborhoods, locate potential consumers of service who have not become consumers, find out why they have not, and take the necessary steps to overcome or bypass the obstacles.

Within the context of the objectives of the Health Care Expediter Program, one specific activity undertaken was the launching of a health care needs survey in the three target neighborhoods during the months of October, November, and December, 1969. Entitled "A Survey of Consumer Utilization of, Views on and Suggestions for Health Care Services in Three Disadvantaged Neighborhoods

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in Pittsburgh, Pennsylvania," the survey had a number of objectives related to program activities and planning:

1. To identify gaps in service as perceived by residents in the three target neighborhoods.

2. To generate recommendations as to how the gaps might best be filled based upon information supplied by consumers and potential consumers of health care services.

3. To better familiarize the expediters with their communities.

4. To provide each family interviewed with a packet of relevant health information pamphlets.

5. To permit the expediters to systematically approach people in their neighborhoods on a door-to-door basis in an attempt to explore the feasibility of this approach to reaching some of the more isolated and apathetic residents and, hence, the ones perhaps most in need of help.

6. To casefind in the sense that in all situations where need for service was uncovered necessary action was taken to insure the provision of such needed service.

7. To provide certain kinds of baseline data to be used in planning future activities, in plotting new directions for the Health Care Expediter Program, and for future evaluation and assessment of the program's effectiveness.

This study is a secondary analysis of some of the data thus collected in the three target neighborhoods (the Hill District, South Oakland, and Hazelwood). The study is concerned with the analysis of two major health related

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variables: (1) the views of neighborhood residents concerning the health care available to them, and (2) their utilization of health care.

Study Objectives

In connection with the analysis of the above variables of attitudes and utilization, a number of specific objectives were set forth:

1. To describe how residents in three local contiguous poverty neighborhoods view health care available to them and how their families utilize health care services. We sought to get a picture of these attitudes and family utilization for the sample as a whole. Within this context, we were also interested to see how these two variables were related to race, age, education, and income in this population.

2. To describe these views toward, and utilization of, health care by families of residents in each neighborhood in comparison to each other and to the total sample and to observe within the neighborhoods how such views and utilization were related to race, age, education, and income. By doing so, we expected to find out whether important information about each neighborhood in connection with these variables was lost in the aggregation of data for all three.

3. To examine the influence of the neighborhood of residence on the respondents' views toward and their families' utilization of available health care. We also wanted to find out the effect, if any, of the neighborhood

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of residence on relationships between expressed views and utilization and race, age, education, and income. Thus, we were interested to learn whether the neighborhood in which one resides might influence his attitudes and utilization, independent of socioeconomic and demographic factors. In this connection, also, since availability of health care, both geographic and economic, can be uneven from one neighborhood to the next, we were interested to see what influence this might have on any differential in utilization observed in the different neighborhoods.

Assumptions

In connection with the above objectives the following assumptions were made:

1. Aggregated data for the three study neighborhoods will replicate findings of other studies in terms of the relationship between socioeconomic and demographic variables of age, income, education, and race and variables of utilization.

2. Residents' views of available health care will be positive in all socioeconomic and demographic groupings.

3. There will be differences among residents from community to community in their utilization of health services and in their views of available health care.

4. Differences among residents in their utilization of health services and in their views of available health care will remain even when holding socioeconomic and demographic factors constant and will not be explained by variation in availability of health care services among the neighborhoods.

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The Variable Indicators

The following operationally define the study variables in terms of the specific indicators employed for analysis:

Views of Available Health Care.

1. Changed doctors or clinics in the past year.
2. Thought of changing doctors or clinics.
3. Preferred source of treatment.
4. Opinion on where people on welfare can go for treatment.
5. Opinion on equality of treatment for people on welfare.
6. Assessment of adequacy of health care in the community.

Utilization of Health Care Facilities.

1. Delaying needed health care.
2. Uncared for dental problems.
3. Treated in past year by any source.
4. Number of visits to all sources of treatment in past year.

Neighborhood. Defined by census tract in accordance with the designation by Community Action Pittsburgh. (See following section.)

Race. Only blacks and whites are considered.

Age. Age of the female head of the household in cohorts.

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Education. Number of years of school completed by female head of the household in cohorts.

Income. Total amount of annual income all sources.

Availability. Geographic and economic accessibility.

Method

The Universe

As indicated earlier in this chapter, three neighborhoods designated by Community Action Pittsburgh, Inc., as poverty areas were selected for study. Selection of these three neighborhoods was based upon their being the only three of the eight such poverty areas in the primary service area of Presbyterian-University Hospital and, consequently, the target population for the Health Care Expediter Program. The three neighborhoods (the Hill District, South Oakland, and Hazelwood) are contiguous and rank first, sixth, and eighth respectively in priority on the city's poverty roster. The poverty designations were ascribed to all eight areas because most of Pittsburgh's 154,000 poor, as defined by Office of Economic Opportunity standards (annual income of $3,200 per year or less), live in them. Also, they have the highest percentage of unemployment, lowest median incomes and educational levels, and the worst housing and

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health standards in the entire city.[1]

The Hill District is comprised of census tracts 1B, 3A, 3F, 3G, 3H, 4A, 5C, 5D, 5F, 5G, 5H, 5I, 5K, and 5L. It is located predominantly in Pittsburgh's fifth ward and stretches from the edge of downtown Pittsburgh to the edge of the University of Pittsburgh's Oakland campus. Being the best known black ghetto and having the worst health and housing conditions, it has been the most studied. Many service agencies and black cultural centers, as well as a number of outreach health care facilities and a major hospital, are located within its borders.

In 1960 the Hill's population of 42,091 represented 16.6 percent of the target population for anti-poverty efforts and 7 percent of the city's total population. In 1967-1968 it was estimated that the Hill had lost 10,668 persons, a 25.3 percent loss. Thus, most recent indications are that there are currently approximately 31,297 people in 10,194 households, averaging 3.07 persons per household. The population is predominantly black, 88.6 percent, and there is a large elderly population.

South Oakland is comprised of census tracts 4C, 4D, 4E, 4I, 4J, 4FA, 4FB, and 5J and is located in the city's

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[1]Community Action Pittsburgh, Inc., Target Neighborhood Report: Social and Economic Conditions and Programs (Pittsburgh: Community Action Pittsburgh: Community Action Pittsburgh, Inc., 1969), p. 5. (Mimeographed.) The following descriptions of the study neighborhoods, unless otherwise footnoted, are contained in this report on pp. II-6-7, 12-13, 15-16.

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fourth ward next to two universities: University of Pittsburgh and Carnegie-Mellon University. South Oakland's population has a large number of students and other transitory residents. It is, therefore, largely a university community containing many small businesses catering to the needs of students and faculty. In addition, because all the hospitals of the University Health Center of Pittsburgh are located in South Oakland, there is a disproportionately large number of medical specialists who have offices in this neighborhood.[2]

In 1960 there were 15,595 people in South Oakland representing 2.5 percent of the city's population. However, by 1967-1968 it was estimated that the community lost 30.3 percent of its population, 4,719 fewer people. Thus, South Oakland currently has 10,876 people in 3,577 households, averaging 3.04 persons per household. Its population is predominantly white, 85.7 percent, from a variety of ethnic backgrounds. All blacks in this neighborhood live in only two census tracts--4I and 4J.

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[2]In a personal communication with the Allegheny County Medical Society, the author was informed that there are over 500 physicians listed for South Oakland, while only four are listed for Hazelwood and five for the Hill. However, many of the physicians in South Oakland are either specialists who serve the entire county or Tri-state area or are on the faculty and staff of the medical school and the Health Center hospitals. No breakdown was available concerning how many physicians were in general practice serving the health care needs of the South Oakland community.

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Hazelwood includes census tracts 15C, 15D, 15EA, 15EB, 15EC, and is in Pittsburgh's fifteenth ward. The Pittsburgh mill of the Jones and Laughlin Steel Company is situated in Hazelwood, and many Hazelwood residents are employed there. Bordering the Monongehela River, Hazelwood is geographically contiguous to but somewhat isolated from South Oakland because of the topography of the area and the poor public transportation linking the two communities. Hazelwood has few medical facilities of its own, thus making it necessary for many to go outside the neighborhood for medical care. However, to get to the South Oakland medical facilities by public transportation requires a bus trip to downtown Pittsburgh and a transfer from there to a bus going into Oakland.

In 1960 Hazelwood's population of 17,298 represented 6.9 percent of the population in the eight poverty neighborhoods and 2.9 percent of the city's population. However, in 1967-1968 it was estimated that Hazelwood, as the other study neighborhoods, lost 3,745 people, a 21.6 percent loss. There are by current estimates 13,553 people in 4,021 households, averaging 3.7 persons per household. Hazelwood is racially mixed, 67.6 percent white representing many ethnic groups and 32.4 percent black. This racial admixture evolved within the decade since 1960, for in the 1960 census Hazelwood was 85.4 percent white. Hazelwood has been a racially troubled area where feelings have erupted into occasional

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violence. Many of its residents are contesting its designation as a poverty area.

For additional information concerning the study neighborhoods, especially in the area of health, see the tables in Appendix B.

The Sample

The sample was selected from lists of dwelling units in the neighborhoods obtained from Southwestern Pennsylvania Regional Planning Association and the Community Study Center of Western Psychiatric Institue and Clinic. From these lists, employing a table of random numbers, 100 dwelling units in each neighborhood were selected for inclusion in the study. Further, within each dwelling unit only one household was included. The sample, thus, was stratified for neighborhood to insure that each one had an equal number of potential respondents. The figure of 100 dwelling units was chosen out of practical considerations, viz. feasibility of collecting the data within a reasonable time span since all the interviews were conducted by three people. Nevertheless the total sample of 300 households represented 1.7 percent of all household units in the three neighborhoods combined and one percent, 3 percent, and 2 percent of the household units in the Hill District, South Oakland, and Hazelwood respectively. Since these low percentages could raise questions as to the representativeness of the sample, despite its random selection, the percentage

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distribution of key socioeconomic and demographic characteristics of the sample, when tabulated, were checked against the percentage distribution of the same characteristics found in other surveys and studies conducted in the same areas. In so doing it was found that the percentage distribution for race, age, income, education, number of children under 21 and type of dwelling unit in this sample was essentially the same as that found in other studies, thereby lending more confidence to the representativeness of the sample.

Data Collection

The Instrument (Appendix A). The instrument employed for data collection was a structured interview questionnaire with some open-ended subparts to permit elaboration on answers to certain questions. The instrument was divided into four basic sections. The first section asked questions related to utilization of health care services. The second section was addressed to collecting information related to the health of the respondent and family. Section three contained items concerning opinions and attitudes of the respondents toward available health care. The fourth, and final, section dealt with socioeconomic and demographic data.

Validity and reliability of the questions were assumed based on their having been employed time and again in a multitude of studies. However, because many items were

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rearranged in their adaptation for use in this study, a pretest was run in the same population from which the sample was drawn to determine the length of time it would take to complete an interview, the feasibility of its administration, and the clarity of the questions. As a result of the pretest, certain items were reordered, others entailed a change in wording to eliminate ambiguities and biases, and still others were broken down into subparts because the original questions were too cumbersome. The instrument took between three quarters of an hour to an hour for the interviewer to complete.

The Interviewers. As noted earlier, the survey was undertaken as a Health Care Expediter Program activity related to certain program objectives. One of these objectives was to better familiarize the Health Care Expediters with their communities. Health Care Expediters themselves conducted all data collection interviews. Three expediters, each one indigenous to one of the study neighborhoods and with specific responsibility to represent her community's health interests to the hospital, were selected to carry out all interviews in their respective neighborhoods.

These expediters were trained by this investigator for one month prior to data collection. Training consisted of learning principles and techniques of interviewing, complete familiarization with the purpose of the survey and its relationship to their jobs, and thorough knowledge of the

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instrument's structure and content. In order to insure their being at ease with the instrument and consequently to enhance their ability to use it effectively, they were encouraged to comment on it, to question any part of it, and to suggest any changes they felt would make it easier for them to administer.

The Data Collection Process. Data collection began in October, 1969, and continued through January, 1970 with all interviews in one neighborhood conducted by the same interviewer. For several reasons, wherever and whenever possible the person interviewed was the female head of the family. It was felt that the female head of the family would be likely to possess more of the information requested for her family than would the male head. Secondly, since interviewing was to have been accomplished for the most part during the day, she would be more likely to be home than the male head. Finally, it is known that many low-income families are headed by females with no male counterparts in the home, and their inclusion as respondents was thus assured. However, the interviewers were instructed that in those cases where there was no female head of the family, i.e., where single, widowed, divorced, or separated men identified themselves as head of their household, such male head of household should be interviewed. A household unit was defined as consisting of either an individual living alone or with a nonrelated person (or persons), a married

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couple, or a parent or parents and their children. In the event of two or more household units living in the same apartment, the person interviewed was the female head of the household unit whose member answered the door.

Each interviewer carried with her to the interview her Presbyterian-University Hospital employee identification card, a personal business card, and a packet of health information booklets and pamphlets which were given to each family contacted, whether or not they agreed to participate in the study. Each prospective respondent was approached in the same way by the Health Care Expediter interviewer. Since names of respondents included in the sample were not known in advance, no prior appointments were made. The interviewer appeared at the selected address and apartment number and introduced herself showing proper credentials and stated the purpose of her visit with a prepared introductory statement which she memorized (see statement on top of page 1 of the Instrument, Appendix A). If the first attempt to contact the respondent was unsuccessful, at least three more attempts were made before the respondent was relegated to the unable to contact category.

The response rates were 95 percent, 90 percent, and 75 percent in the Hill, South Oakland, and Hazelwood respectively and 86.7 percent for the whole sample.

Data Processing. The data were edited, categorized, and were coded for tabulation on the University of Pittsburgh

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IBM 360 computer. Two computer program packages were used to analyze the data. For initial tabulations of marginals, the "Codebook" program of the SPSS (Statistical Package for the Social Sciences) package was utilized. For crosstab analysis the "Crosstab" program of the SPSS package was employed.

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CHAPTER III

UTILIZATION OF HEALTH CARE

In Chapter I it was suggested that there is danger in applying to specific communities or localities findings with respect to utilization of health care in low-income areas from studies of national samples or samples from different locales. It was further suggested that since communities are unique, despite similarities in their socioeconomic and demographic characteristics, much of their individuality can be obscured in the aggregation of data. In addition, it was posited that for planning health care programs on a local level with particular target areas in mind, much information needs to be collected within the areas to be served. This is especially necessary now with the current emphasis by professional and citizens alike on the importance to the success of a program of consulting those to be served.

The literature has reflected the fact that the poor utilize fewer health care services than those who are economically better off. Further it was found in the literature that the poor are likelier than the more advantaged to rely heavily on nonprofessional sources for their health care.

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One of the objectives of this study was to explore and describe the utilization of residents in three local contiguous poverty neighborhoods in a major eastern urban area. Specifically, we wanted to see whether utilization in the study population was generally comparable to that observed in the study of other poverty areas. Also we were interested in seeing whether neighborhood, as an independent variable, was associated with utilization of health care, i.e., whether there existed substantial differences in utilization among residents in the study population when stratified by their particular neighborhood of residence.

In connection with the last area of interest mentioned above, the importance of where one lives as a factor in utilization, two main objectives were specifically set forth. One objective in looking at utilization stratified by neighborhood was to observe whether important utilization information with respect to the individual neighborhoods was lost in the aggregation of the data on the three communities which comprised the study population. The second specific objective with respect to the study of utilization in each neighborhood separately was to explore the following general question: whether there is an association between the neighborhood in which one lives and utilization of health care.

With the above in mind, the findings in connection with utilization of health care are described and analyzed on the following pages.

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General Level of Utilization Among The Study Population

The level of utilization of health care in the study population was found to be very high. The overwhelming majority of families, 72.3 percent, indicated that they had a personal family physician. Slightly more than half of the families, 50.8 percent, had a regular family dentist. This difference between having a family doctor and having a family dentist is consistent with the national trend where dental care is generally on a lower priority than is medical care. Nevertheless, a note of caution must be inserted before this is accepted as an indication of actual utilization, because the simple assertion that a family has a doctor and/or dentist, although frequently employed as such, is at best a questionable indicator of actual utilization. Respondents were, therefore, asked when the last time was that anyone in the family had actually utilized a health care facility for medical or dental care and fully 85.3 percent responded that the last utilization experience was within the twelve months preceding the interview. Only 7.3 percent of the families had had no medical contact in two years preceding the study and only 4.6 percent of the families had had no medical contact in more than two years.

With respect to the particular health resources utilized for those families who used them, it was found that virtually all of them had gone to professional sources for

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their care, namely hospitals, clinics, and private doctors, either solely or in combination. The median number of visits in the past year to all sources of health care was 4.5 visits per family. Similarly, professionals were relied upon as a primary source of health information by the large majority of 78.8 percent of the families. It was also found that only small percentages of families said they were postponing needed health or dental care (23.5 percent and 24.2 percent respectively). One aspect of utilization among the study population reflected the national trend of people generally to defer seeking medical attention when first signs of illness appear, 65.4 percent indicated that when ill they wait to see what happens before seeking medical attention.

Thus, it can be seen that on almost all indicators of health care utilization employed in this study, the residents of the surveyed neighborhoods may be described as high utilizers of available professional health care resources. For all ages, for blacks and whites, and for all educational and income levels, the observed high utilization obtained in our study population.

For the purpose of further analysis, four indicators of health care utilization were employed: (1) families currently delaying needed health care, (2) families having uncared for dental problems, (3) families which had utilized health care from any professional source in the past year,

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and (4) total number of professional medical contacts in the year. These four indicators were selected because they represent important aspects of utilization.

The four utilization indicators are presented from the general to the specific and from nonutilization to utilization. Thus, the first two indicators, "delaying needed health care" and "uncared for dental problems," suggest nonutilization of health care services in general. In other words, those who responded that they had uncared for medical and/or dental problems were assumed not to be utilizing needed health care services. Consequently, in those two response categories the higher the percentage who responded "yes," the lower the utilization of health care services.

On the other hand, the third indicator, "treated in past year by any source" measures utilization experience within a specified time span. Thus, the higher the percentage of positive responses the greater the utilization. The last item, "total professional medical contacts in the year," represents an actual count of the number of visits made to professional medical sources by those who had utilization experience in the past year. Thus, we found out not only that health care services were used in the past year, but also how many times they were used.

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Utilization by Neighborhood

In general, as stated before, it was found that the study population's utilization of health care was high. We were, however, interested to see whether important differences in utilization occurred among families in the three neighborhoods (the Hill District, South Oakland, and Hazelwood) which comprised the study population.[1]

Table 4 relates utilization to the neighborhood in which the respondent lived. It will be recalled that three of eight poverty neighborhoods in Pittsburgh, so defined and designated by Community Action Pittsburgh, Inc. (CAP), were selected for inclusion in this study. Their selection was based upon their being the only three low-income neighborhoods in the primary service area of Presbyterian-University Hospital. Therefore, the study neighborhoods are

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[1]Important differences were defined as at least a 10 percentage point spread. No statistical tests were employed to determine the level of significance of any observed differences. Such tests could not be validly used with any degree of consistency in the study data because in many instances, especially where the N was small, the number of responses in the categories did not meet the technical criteria for the application of tests of significance. Because of the nature of the data, in some instances this was true even when the N was large enough for us to have considered the application of a test of significance. To have used tests of significance only sporadically and inconsistently would have hindered rather than helped the analysis because interpretation would have been extremely difficult. Selvin questions whether tests of significance can ever be validly used in survey research because the conditions for their use are almost impossible to fulfill in this type of research. For his full argument, see Hanan C. Selvin, "A Critique of Tests of Significance in Survey Research," American Sociological Review, XXII (1957), 519-527.

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TABLE 4

FAMILIES' UTILIZATION OF HEALTH SERVICES BY NEIGHBORHOOD

Utilization[A]		Neighborhood			Total Study Population
		Hill %	South Oakland %	Hazelwood %	
Delaying needed health care	Yes	39.4	16.7	12.0	23.5
	No	60.6	83.3	88.0	76.5
		N=(94)	(90)	(75)	(259)
Uncared for dental problems	Yes	35.1	24.7	10.7	24.2
	No	64.9	75.3	89.3	75.8
		N=(94)	(89)	(75)	(258)
Treated in past year by any source	Yes	84.2	81.1	82.7	83.1
	No	15.8	18.9	17.3	16.9
		N=(95)	(90)	(75)	(260)
Total professional medical contacts in the year[B]	1-5	48.6	81.9	71.0	66.8
	Over 5	50.4	18.1	29.0	33.2
		N=(74)	(72)	(62)	(208)

[A]In the interest of an unencumbered presentation of the data and since the percentage of such responses was small, the "no response" and "don't know" categories were eliminated from this analysis thereby changing the base for computation of percentages. This accounts for the slightly changing N's from one item to another.

[B]This item refers only to those who indicated that they had professional medical treatment in the past year and who also indicated the number of such visits made. The above item shows the percentage who had no medical contacts and thus no visits within the past year.

presented on the table in the priority order in which they appear on CAP's roster of designated target poverty areas. The Hill District, which is first on CAP's roster, appears first in the table. South Oakland, which is sixth of the eight CAP designated poverty neighborhoods, is presented second on the table, while Hazelwood, number eight on the poverty roster, is last in the order.

It is clear that utilization is associated with neighborhood on three of the four indicators employed: "delaying needed health care," "uncared for dental problems," and "total number of medical contacts in the year." More than one-third of the families in the Hill District are putting off needed medical care which is more than twice the proportion of such families in South Oakland and more than three times the proportion of those in Hazelwood. It appears, therefore, on this indicator, that the association tends in the direction of the neighborhood's priority target designation; that is, the lowest utilization appears in the top priority low-income neighborhood and the highest utilization is found in the lowest priority neighborhood.

A similar association was found between utilization of dental care and neighborhood. The proportion of families with uncared for dental problems in the Hill District is almost half again as much as families in South Oakland which reported uncared for dental problems and more than three times the proportion of such families in Hazelwood--35.1

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percent, 24.7 percent, and 10.7 percent respectively. Thus, the strength and the direction of the association between utilization and neighborhood are very close for both medical care and dental care.

Within each neighborhood, however, little differential was found between utilization of medical care and utilization of dental care, the largest difference between them (8 percentage points) occurring in South Oakland. This finding among our study population is apparently in conflict with the results of studies of other similar populations which have shown utilization of dental care to be much lower than utilization of medical care. This lends some support to the contention that in planning and programming for a particular community, the specific application of findings from one population to another similar population can be misleading. This emphasizes the importance of establishing at least some baseline data on the particular community to be served.

The third indicator of utilization, families in which someone has received treatment in the past year, is addressed to the actual utilization experience within the twelve months preceding the interview. As noted before, the overwhelming majority of families in the total study population had utilized a professional source of health care within the year. When analyzed by neighborhood, no substantial differences in utilization experience were found. In

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other words, families in each neighborhood were equally likely to have had treatment contacts within the year. However, differences were observed among families in the different neighborhoods in the number of such visits during the year. Among those families responding that they had had professional medical contacts within the year preceding the interview who also indicated the number of visits, slightly more than half the families in the Hill District, 50.4 percent, had in excess of five such contacts. However, only 18.1 percent and 29.0 percent of the families in South Oakland and Hazelwood, respectively, had more than five medical contacts within the year. Thus, the difference among the communities in regard to number of medical contacts during the year were substantial, and families in the Hill District stood out as being by far the highest utilizers among those families with utilization experience in the past year. However, since their utilization as reflected by the other indicators was found to be generally lower than in the other neighborhoods, this finding with respect to total medical contacts within the year appears contradictory. An explanation for the discrepancy might lie in differences in levels of health in the communities. One of the known characteristics of the Hill and one which placed it on top of CAP's priority list for anti-poverty efforts, is its generally lower level of health than in the other poverty areas. Thus, as an indicator, the total

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number of medical contacts in any given year might be more reflective of the level of health in the population than a measure of its utilization. However, its employment in this study as an indicator of utilization along with the other indicators was based upon its common usage as such in most studies of utilization and was valuable for the purpose of exploring differences among the neighborhoods in their overall utilization of health care resources. Secondly, we were interested to find out whether important utilization information with respect to individual neighborhoods was lost in the aggregation of data for all three. Referring back to Table 4, page 51, it is clear that, even in the same geographic area among a population residing in contiguous neighborhoods, the data, when aggregated, obscures important information on the individual communities as reflected by the substantial utilization differences among the communities and between each one compared with the aggregated total. If this holds for a population which resides in the same geographic area, so much more so should it for populations that are geographically separated.

It has been shown that utilization was related to neighborhood in three out of the four indicators employed. The fourth indicator, actual utilization of medical care in the past year, showed no apparent association with neighborhood of residence. The next step, then, in the analysis was to attempt to account for these findings by the

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introduction of a test factor, a third variable known to be associated with both the independent variable (neighborhood) and the dependent variable (utilization). The purpose of introducing the test factor was to see whether the neighborhood variable was actually a factor influencing utilization or whether the observed association between them was perhaps due to a third variable. In other words, we wanted to know if there would have been no association between neighborhood and utilization were it not for the third variable. As test factors, four socioeconomic and demographic variables were selected: race, age, education, and income. Each one of these has been found in other studies to be independently associated with utilization. Also, each has been found in this study to be related to neighborhood as Table 5 demonstrates. Thus, if the observed association between utilization and neighborhood of residence were due to the third variable introduced as a test factor, the original observed relationship should have disappeared in each contingent group of the independent variable being controlled.[1] The results of this analysis are presented separately for each test factor.

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[1]For an extensive discussion of the logic of introducing a test factor see Morris Rosenberg, The Logic of Survey Analysis (New York: Basic Books, Inc., 1968), especially Chapters 2, 3, and 4.

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TABLE 5

RACE, AGE, EDUCATION AND INCOME BY NEIGHBORHOOD

Socioeconomic and Demographic Characteristics	Neighborhood		
	Hill %	South Oakland %	Hazelwood %
Race			
White	12.6	85.4*	77.3
Black	87.4	14.6	22.7
	N=(95)**	(82)	(75)
Age			
Under 40	25.0	50.6	21.7
40 - 60	29.5	37.7	54.0
Over 60	44.5	11.8	24.4
	N=(88)	(85)	(74)
Education			
Under 9 years	27.9	22.9	36.4
9 - 12 years	51.7	50.6	60.9
Over 12 years	11.4	26.5	2.8
	N=(87)	(83)	(74)
Income			
Under $4,000	65.2	32.5	41.9
$4,000 - $8,000	20.7	42.5	31.1
Over $8,000	14.1	25.0	27.0
	N=(92)	(80)	(74)

*Only blacks and whites are considered; orientals and other racial groups appeared only in South Oakland in our sample and were eliminated changing the base for percentage computation.

**N reflects only those who responded on the item thus the differing N's from item to item.

Neighborhood Utilization by Race

Table 6 shows the results when utilization was cross-tabulated with neighborhood controlling on race. It is clear that race does not account for the relationship between utilization and neighborhood. In each factor of utilization where there had been a relationship between utilization and neighborhood, the association remained within the contingent groups with the single exception of blacks who had uncared for dental problems where the differences among the communities became negligible. Nevertheless, among whites differences among the neighborhoods remained fairly substantial. That is not to say that race has no bearing at all on the relationship between utilization and neighborhood. The influence of race can be seen in the fact that the degree of association was altered with its introduction in each factor of utilization. Nevertheless, the variable race could not account for the differences in utilization among the neighborhoods. Also the influence of race as a suppressor variable is shown by the fact that whereas no association between utilization and neighborhood was found in the percentage of families having had treatment in the past year, a slight association did occur when race was introduced into the analysis. Thus, it would appear that although race is an influencing factor in utilization, neighborhood is also related to utilization independent of race.

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TABLE 6

UTILIZATION OF HEALTH SERVICES BY NEIGHBORHOOD CONTROLLING FOR RACE

Utilization*		Neighborhood					
		White			Black		
		Hill %	South Oakland %	Hazel-wood %	Hill %	South Oakland %	Hazel-wood %
Delaying needed health care	Yes	27.3	17.1	12.1	41.0	16.7	11.8
	No	72.7	82.9	87.9	59.0	83.3	88.2
		N=(11)	(70)	(58)	(83)	(12)	(17)
Uncared for dental problems	Yes	18.2	26.1	5.2	37.3	33.3	29.4
	No	81.8	73.9	94.8	62.7	66.7	70.6
		N=(11)	(69)	(58)	(83)	(12)	(17)
Treated in past year by any source	Yes	83.3	82.9	79.3	84.3	91.7	100.0
	No	16.7	17.1	20.7	15.7	8.3	0.0
		N=(12)	(70)	(58)	(83)	(12)	(17)
Total professional medical contacts in the year**	1-5	40.0	84.2	64.4	50.0	81.8	88.2
	Over 5	60.0	15.8	35.6	50.0	18.2	11.8
		N=(10)	(57)	(45)	(64)	(11)	(17)

*Refer to note A, Table 4, page 51.

**Refer to note B, Table 4, page 51.

Another interesting finding can be seen in Table 6 relative to the association between race and utilization within each neighborhood. This finding also gives support to the conclusion that neighborhood is an important and independent factor in utilization. Looking at those families delaying needed health care, we found that race is strongly associated with this aspect of utilization in the Hill District but not in the other two neighborhoods. For those families with uncared for dental problems, the association between race and utilization is strong in the Hill District and in Hazelwood, but not as strong in South Oakland. Similar differentials in the relationship between race and utilization within the communities were found on the other factors of utilization, viz., those who had treatment experience within the past year and the total number of medical contacts in the year. This would seem to indicate that neighborhood of residence is a strong mediating influence on the relationship between race and utilization. To the extent this is so, it would be extremely important for research and planning purposes to take into consideration where people live as well as their other socioeconomic and demographic characteristics.

Neighborhood Utilization by Age

Since race was found to be an influencing factor in utilization but was not found to be responsible for the

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relationship between utilization and neighborhood, it was thought that perhaps the original observed association between neighborhood and utilization might be due to age which has also been found to be related to both utilization and neighborhood. For the purpose of this study, which was concerned with family rather than individual utilization of health care, the age of the female head of the household was selected as the test factor variable.

Age of the female head of the household was selected for this purpose for several reasons. Many families in the study neighborhoods were headed by females with no spouse. However, there were very few male heads of household without a spouse, only 12, or 4.2 percent of the entire sample. Consequently, using the age of the female head of household permitted the inclusion of a larger number of family units for analysis. Secondly, in each family which was headed by a male and female, the age differential between them was minimal, i.e., they fell into the same age cohort. Finally, it was assumed that the female head of the household was more likely than the male head to directly influence the health care practices of the entire family, and hence its utilization of health care. Thus, to the extent age is a factor in the family's utilization of health care, it was assumed that the age of the woman would be a more cogent influence than that of the man.

Thus, the four indicators of utilization were cross-tabulated with neighborhood of residence controlling for age

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of the female head of the household. The results of this are presented in Table 7. As can be readily observed in Table 7, age of the female heads of the household does not eliminate the relationship between neighborhood and utilization on any of the indicators. In every age group the original relationship between neighborhood and utilization held up. Nevertheless, the original observed relationships between neighborhood and utilization were altered in varying degrees under the influence of age. Thus, as was found with race, age is an influencing factor in utilization although to a lesser degree.

The role of age as a suppressor variable is evident on the indicator "families which had medical treatment in the past year." Whereas no relationship between this indicator of utilization and neighborhood was observed initially, under the influence of age a relationship emerged. Were it not for the factor of age there would have been an association between neighborhood and utilization as reflected by families who utilized health care in the past year. Therefore, additional support was found for the importance of where one lives as an independent factor influencing his utilization of health care.

Additional evidence of the importance of neighborhood of residence as a strong independent factor in utilization may also be seen in Table 7. Within each neighborhood the relationship between age and utilization on each

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TABLE 7

UTILIZATION OF HEALTH SERVICES BY NEIGHBORHOOD CONTROLLING FOR AGE

Utilization*		Neighborhood								
		Under 40			40 - 60			Over 60		
		Hill %	South Oakl. %	Hazel-wood %	Hill %	South Oakl. %	Hazel-wood %	Hill %	South Oakl. %	Hazel-wood %
Delaying needed health care	Yes	40.9	16.3	6.3	48.5	18.8	20.0	34.4	10.0	0.0
	No	59.1	83.7	93.7	51.5	81.2	80.0	65.6	90.0	100.0
		N=(22)	(43)	(16)	(33)	(32)	(40)	(32)	(10)	(18)
Uncared for dental problems	Yes	50.0	37.2	12.5	42.4	18.8	10.0	25.0	0.0	11.1
	No	50.0	62.8	87.5	57.6	81.2	90.0	75.0	100.0	88.9
		N=(22)	(43)	(16)	(33)	(32)	(40)	(32)	(10)	(18)
Treated in past year by any source	Yes	95.2	79.1	75.0	73.5	84.4	87.5	90.6	90.0	77.7
	No	4.8	20.9	25.0	26.5	15.6	12.5	9.4	10.0	22.3
		N=(21)	(43)	(16)	(34)	(32)	(40)	(32)	(10)	(18)
Total professional medical contact in past year**	1-5	47.4	75.8	66.7	54.2	81.5	68.6	36.0	100.0	78.6
	Over 5	52.6	24.3	33.3	45.8	18.5	31.4	64.0	0.0	21.4
		N=(19)	(33)	(12)	(24)	(27)	(35)	(25)	(9)	(14)

*Refer to note A, Table 4, page 51.

**Refer to note B, Table 4, page 51.

indicator differs from one neighborhood to another, reflecting the strong mediating influence of the particular neighborhood on how the families within it utilize health care. For the most part, families in the same neighborhoods are closer to one another in their utilization of health care regardless of their age, than are people in the same age categories but in different neighborhoods.

Neighborhood Utilization by Education

Neither race nor age were found to be responsible for the association between neighborhood of residence and utilization of health care, thus lending more confidence that the relationship originally observed was genuine and not an artifact of either race or age. Nevertheless, the possibility existed that level of education might be responsible for the association, and so level of education was superimposed on the relationship between neighborhood and utilization in the same manner as had been done with the variables of race and age.

The education variable employed in this study was the educational achievement of the female head of the household. The selection of the female head of the household's educational level as the controlling variable was based upon essentially the same reasoning and assumptions which led to the decision to use her age as the test factor in the preceding analysis; viz., the larger number of female

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heads in the sample, their key role in determining their family's health practices, and the assumption that to the extent educational level is an important factor in utilization it is the woman's education that is crucial.

The results obtained when crosstabulating the four indicators of utilization with neighborhood, controlling for education, as defined above, are presented in Table 8. This table reveals that the original relationship between utilization and neighborhood did not vanish in each contingent group on the education variable. Nor in fact did the degree of association on any of the utilization indicators change very much within contingent groups. This suggests that for the most part among our study population education is a factor of minimal consequence in the utilization of health care. Within each neighborhood, however, there does seem to be some association between educational level and utilization of health care on each of the indicators. Yet this association is ambiguous in that it shows no consistent pattern either in direction or strength. It is possible that these inconsistencies could be explained on the basis of a strong neighborhood influence on the overall patterns of utilization among the various education groups which reside within it. However, be that as it may, it is quite clear that education was not able to explain the differences in utilization among the neighborhoods.

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TABLE 8

UTILIZATION OF HEALTH SERVICES BY NEIGHBORHOOD CONTROLLING FOR EDUCATION

Utilization*		Neighborhood								
		Under 9 years			9-12 years			Over 12 years		
		Hill %	South Oakl. %	Hazel-wood %	Hill %	South Oakl. %	Hazel-wood %	Hill %	South Oakl. %	Hazel-wood %
Delaying needed health care	Yes	42.4	21.1	3.7	40.9	21.4	17.8	33.3	4.5	0.0
	No	57.6	78.9	96.3	59.1	78.6	82.2	66.7	95.5	100.0
		N=(33)	(19)	(27)	(44)	(42)	(45)	(9)	(22)	(2)
Uncared for dental problems	Yes	30.3	22.2	11.1	43.2	31.0	8.9	44.4	22.7	50.0
	No	69.7	77.8	88.9	56.8	69.0	91.1	55.6	77.3	50.0
		N=(33)	(18)	(27)	(44)	(42)	(45)	(9)	(22)	(2)
Treated in past by any source	Yes	81.8	84.2	77.7	86.7	90.5	86.7	88.9	68.2	100.0
	No	18.2	15.8	22.3	13.3	9.5	13.3	11.1	31.8	0.0
		N=(33)	(19)	(27)	(45)	(42)	(45)	(9)	(22)	(2)
Total number of professional medical contacts**	1-5	47.8	81.3	59.1	47.2	86.8	75.7	33.3	64.3	100.0
	Over 5	52.2	18.7	40.9	52.8	13.2	24.3	66.7	35.7	0.0
		N=(23)	(16)	(22)	(36)	(38)	(37)	(9)	(14)	(2)

*Refer to note A, Table 4, page 51.

**Refer to note B, Table 4, page 51.

Neighborhood Utilization by Income

The last independent variable to be employed as a test factor in this study in an attempt to explain the association between utilization of health care and neighborhood of residence was family income. As defined in this study, family income referred to the total amount of money coming in to the family during the year, from all sources, not just from employment. This variable therefore included all the money at the family's disposal.

The results achieved when the four utilization indicators were crosstabulated with neighborhood controlling on the income variable are presented in Table 9. Clearly the table shows that family income does not completely account for the differences in utilization among families in the different neighborhoods. The association between utilization and neighborhood did not disappear in each income contingent on any of the utilization indicators employed. At best, the influence of income on the relationship between utilization and neighborhood presents a mixed picture. On the indicator "delaying needed health care," for example, the influence of income is minimal in that the differentials in utilization among the neighborhoods changed only slightly in any income contingent. The percentage of families delaying needed health care in any neighborhood did not vary from the original relationship by as many as ten percentage points in any income group. On the indicators "uncared for dental

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TABLE 9

UTILIZATION OF HEALTH SERVICES BY NEIGHBORHOOD CONTROLLING FOR INCOME

Utilization*		Neighborhood								
		Under $4,000			$4,000-$8,000			Over $8,000		
		Hill %	South Oakl. %	Hazel-wood %	Hill %	South Oakl. %	Hazel-wood %	Hill %	South Oakl. %	Hazel-wood %
Delaying needed health care	Yes	41.7	19.2	6.5	42.1	20.6	21.8	30.8	15.0	10.0
	No	58.3	80.8	93.5	57.9	79.4	78.2	69.2	85.0	90.0
		N=(60)	(26)	(31)	(19)	(34)	(23)	(13)	(20)	(20)
Uncared for dental problems	Yes	36.7	23.1	12.9	36.8	33.3	8.7	25.0	25.0	10.0
	No	63.3	76.9	87.1	63.2	66.7	91.3	75.0	75.0	90.0
		N=(60)	(26)	(31)	(19)	(33)	(23)	(12)	(20)	(20)
Treated in past year by any source	Yes	86.7	80.8	83.9	73.7	65.4	91.3	84.6	95.0	75.0
	No	13.3	19.2	16.1	26.3	23.5	8.7	15.4	5.0	25.0
		N=(60)	(26)	(31)	(19)	(34)	(23)	(13)	(20)	(20)
Total professional medical contacts in year**	1-5	44.4	76.2	80.8	64.3	80.8	61.9	41.7	83.3	64.3
	Over 5	56.6	23.8	19.2	35.7	19.2	38.1	58.3	17.7	35.7
		N=(45)	(21)	(26)	(14)	(26)	(21)	(12)	(18)	(14)

*Refer to note A, Table 4, page 51.

**Refer to note B, Table 4, page 51.

problems" and "number of medical contacts in the year" there were some more important variations in the utilization experience of particular neighborhoods in some of the income groups, most notably in the $4,000-$8,000 income range. However, because the major variations which did occur appeared in only one neighborhood, and not the same one, on any indicator and in any income group, it would appear that such variation is more a function of the particular neighborhood than of income.

Additional support for this interpretation is also found in Table 9. Viewing each neighborhood separately, it can be seen that the relationship between income and utilization within a neighborhood varies considerably from one neighborhood to another. That there is no consistency in either the direction of the association between income and utilization or its strength within each of the neighborhoods suggests that the particular neighborhood of residence is an important mediating influence on any relationship between income and utilization. Regardless of income classification, where one lives appears to be an influence on his utilization or nonutilization of health care.

Neighborhood Utilization and Availability

Another important variable normally associated with utilization of health care services is availability. The concept of availability of health care is extremely complex,

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involving a multitude of interrelated factors among which are geographic and economic accessibility. In operational terms geographic accessibility refers to where the health care resources are located in relation to potential consumers. Economic accessibility, on the other hand, may be defined as the extra financial resources available to potential users (such as third-party payments) which enable more extensive and freer use of available health care services. It was recognized that availability of health care is uneven from one community to another and might therefore account for differentials in utilization. However, an extensive analysis of the availability variable as an explanatory factor in the differential utilization of health care services observed among residents in the three study neighborhoods was not possible because of the limitations of the study data. Those data which were relevant to the concept of availability of health care do suggest that availability is an important determinant of utilization. Yet, there was some evidence to suggest that neither the geographic nor the economic definition of availability could fully explain the observed variations in utilization among residents in the different neighborhoods.

The map in Appendix C shows the location of some of the major health care resources in relation to the three study neighborhoods. Whereas all facilities of the Health Center of the University of Pittsburgh are located in South

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Oakland, and a number of health care resources, including Mercy Hospital, are directly in the Hill District, only a well-baby clinic is located in Hazelwood. Since residents in Hazelwood, who had the least geographic accessibility to health care resources were the highest utilizers, it would seem that geographic accessibility does not explain the differences in utilization among residents in the study neighborhoods.

With respect to third party payments, the economic concept of availability, a somewhat different picture emerges. The higher utilization of available health care services among Hazelwood residents than among residents in the other two neighborhoods may well be a function of their high proportion (82.7 percent) who have private health insurance. Of this proportion, 90.3 percent indicated that their policies covered both in-patient and out-patient care. That so many Hazelwood residents hold such insurance may well be due to their numbers employed in the Jones and Laughlin Steel Mill which has a strong health insurance program. On the other hand, a much higher proportion of residents in the Hill District (56.8 percent) than in either of the other neighborhoods have an established eligibility for public payment of medical care. The monetary benefits of such public programs are at least equal to if not better than those available through the most comprehensive private health insurance plans. Among the 46.3 percent of Hill

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District residents who indicated that they had a private health insurance policy, 22.2 percent were covered for both inpatient and outpatient services. Nonetheless, Hill District residents' utilization of health care services was lower than that among residents of South Oakland. Yet, in the latter neighborhood only 21.1 percent of the residents had an established eligibility for public payment of medical care. Further, of the 80.0 percent of South Oakland residents who said they had private health insurance policies, only 6.9 percent had policies which covered both inpatient and outpatient services. Thus, it can be seen that although the Hill District had a much higher proportion of people eligible for public payment of medical care and also had a higher proportion who had both inpatient and outpatient coverage under private insurance than did South Oakland, utilization among the Hill's residents was lower than was utilization in South Oakland. It would appear, then, that availability of third-party payment for medical care does not consistently explain the utilization differences among the study neighborhoods. The variable of neighborhood still appears to be an important influence on utilization.

Summary

In this chapter the overall utilization of health care among the study population was described. It was found that the level of utilization in the study population,

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residents in poverty neighborhoods, was very high on all commonly employed indicators with an overwhelming majority of families having utilized health care services within the year preceding the study period. The median number of visits per family to professional health care facilities in the past year was 4.5. Virtually all families relied heavily on professionals as their source of health care and most relied upon professionals as their primary source of health information. This was true for blacks and whites and for all age, education, and income groups.

Four indicators of utilization were selected for more detailed analysis in connection with exploring the relationship between neighborhood of residence and utilization. It was found that on three of the four indicators of utilization employed there was an association between where the respondents lived and their families' utilization of health care. The differences in utilization among the individual neighborhoods were substantial and tended in the direction of higher utilization among families in the neighborhood with the lowest priority for anti-poverty efforts and lowest in the top priority neighborhood. The one exception to this appeared in the number of times medical treatment was used in the past year by those families having had treatment within the year. In this case the residents in the highest priority poverty area went for treatment more times than those in the other two neighborhoods, thus

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reflecting a higher utilization. The apparent contradiction between the results on this indicator and those on the other more general ones was interpreted as being perhaps more illusory than real. It was suggested that number of total medical contacts in the year may be more indicative of degree of illness-health rather than utilization per se.

It was also found that important utilization information on the three neighborhoods individually was lost in the aggregation of data for the three which comprised the study population. This was reflected in the fact that not only were there substantial differences in utilization from one neighborhood to another but there were also such differences between two neighborhoods and the aggregated total on three out of the four indicators. The third neighborhood differed from the aggregated total on half the indicators.

An attempt to explain the observed association between neighborhood and utilization was made by introducing as test factors four socioeconomic and demographic variables: race, age, education, and income--known throughout the literature to be associated with utilization and found in this study to also be related to neighborhood. None of these test factor variables was able to explain the observed association between neighborhood and utilization. Differences among the neighborhoods remained even when race, age, education, and income were superimposed upon the original observed relationship between neighborhood and utilization.

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Thus, the neighborhood in which one lives was found to be a cogent factor in utilization of health care.

The variable of availability, in its geographic and economic connotations, was discussed as a possible influence accounting for the differences in utilization among the neighborhoods. Insufficient data limited the scope of analysis of this important variable in its relationship to utilization. However, there was some evidence in the data to suggest that neither geographic nor economic accessibility could completely account for utilization differences among the neighborhoods.

Certainly there are other variables which could possibly account for the association between neighborhood and utilization. However, with the limited data and the small samples it was not within the scope of this analysis to have explored further. Nevertheless, having ruled out as explanatory factors the major socioeconomic and demographic variables which are most often associated with utilization as well as geographic and economic accessibility, it can be stated with some confidence that any planning, programming, or research in connection with utilization of services must reckon seriously with the particular communities to be thus served or studied. It should not be assumed that the neighborhoods in the same geographic location and which have many important characteristics in common can be lumped together for massive efforts without regard to their uniqueness.

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CHAPTER IV

VIEWS TOWARD AVAILABLE HEALTH CARE

In the chapter reviewing the literature, it is recalled, it was noted that little is known about how the poor view the health care that is available to them, and need for much more information in that regard was expressed. The Blue Cross Association took some initial steps to fill the need by hiring the Louis Harris organization to conduct a survey of views of the poor concerning health care available to them. The survey was conducted on a national sample and it was found that the majority of the poor gave a positive rating to each category of available medical service and that the percentage differential between such positive attitudes between the poor and the affluent was negligible for the most part. It was also suggested in the first chapter that for planning purposes on the local level it is crucial to explore the views of the population to be served, especially in view of the current emphasis on grass roots involvement in the planning process. Little is known about how the residents in Pittsburgh's poverty neighborhoods view the health care available to them. However, in the 1967-1968 study by CAP it was found that, among residents in the eight local target poverty neighborhoods, attitudes toward services and service institutions, which experts have

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proclaimed seriously deficient, have been overwhelmingly positive. Thus, it was suggested that attitudes toward available health care among this population might also be more positive than one would expect based upon the weight of expert professional opinion.

One of the objectives of this study was to explore opinions of available health care among the study population, residents in three of the eight poverty neighborhoods in Pittsburgh. In so doing we were interested to find out their views toward available health care in general rather than their opinions of specific health care institutions. Nevertheless, some of the items employed for overall descriptive purposes were addressed to elicit views concerning some specific traditional health care institutions.

Findings

Responses of the total study population on selected opinion indicators were as suspected. The views toward available health care were overwhelmingly positive among the study population. Table 10 presents the findings in summary form. The first two indicators on Table 10 ("changed" or "thought of changing doctors or clinics") were selected as descriptive opinion indicators based upon the assumption that they are likely to be expressive of dissatisfaction with the regular source of medical treatment. However, the overwhelming majority (93.8% and 90.8%) had

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TABLE 10

VIEWS OF AVAILABLE HEALTH CARE

Indicators		F*	%
Changed doctors or clinics in past year	No	242	93.8
	Yes	16	6.2
	Total	258	100.0
Thought of changing doctors or clinics	No	218	90.8
	Yes	22	9.2
	Total	240	100.0
Opinion on where welfare patients can get treatment	Certain places only	28	16.6
	Anywhere	201	83.4
	Total	229	100.0
Opinion on equality of treatment for welfare patients	Poorer	65	28.1
	Same	163	70.6
	Better	3	1.3
	Total	231	100.0
Preferred source of treatment	Clinic	26	10.3
	Private doctor	109	43.3
	Emergency room	113	44.8
	Other	4	1.6
	Total	252	100.0
Opinion on adequacy of health care in community	Inadequate	79	33.1
	Adequate	160	66.9
	Total	239	100.0

*Represents only those who expressed an opinion.

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neither changed nor thought of changing doctors or clinics in the past year. Of those who did change or contemplate changing their regular source of treatment, 41.1% gave reasons other than dissatisfaction when elaborating their response.

The next two indicators on Table 10 reflect opinions with respect to discriminatory practices against welfare patients by health care sources. According to the literature, the poor are often constrained in their choice of sources of medical treatment because of discriminatory practices due to their limited income. Also, even in those cases where choices among the poor are not constrained, the service given them has been described as of lesser quality than that given the rest of the population. Welfare patients are a readily identifiable poverty group against whom such discrimination is commonly said to be practiced. Nevertheless, among the study population the opinion expressed by the great majority indicated they feel that not only are the poor not constrained in their choice of treatment source but that treatment received by the poor is equal to that of other groups. As Table 10 demonstrates, 83.4% were of the opinion that welfare patients can go anywhere to obtain treatment and 71.9% felt that the medical treatment received by welfare patients is either equal to or better than that received by others.

Among the study population it is obvious from Table 10 that the preferred sources for medical treatment

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are the traditional professional resources, with private doctor and emergency room care having been preferred by a greater percentage than was clinic care. However, an interesting finding was that, all things being equal, a slightly higher percentage would prefer emergency room care to that of a private physician. From comments made by respondents, it appears that they attribute to the emergency room much of what used to be associated with the family doctor, namely, competent personalized medical care readily available when needed, day or night. Thus, even if it cost the same to be treated by a private doctor and he were just as close as an emergency room, many respondents have no faith that he could or would be available to them when needed.

The last item on Table 10 is one which elicited from the study population a personal general assessment of the adequacy of health care in their communities. A large majority of 66.9% felt that the health care available to them is adequate.

Another item, not included on the table, asked whether the respondent knew of any discrimination by doctors or clinics. Fully 92.7% responded that they did not.

Views of Available Health Care by Neighborhood

We were also interested to see how residents in each one of the neighborhoods viewed the health care available to them. Consequently, the responses on the opinion indicators were crosstabulated with the respondent's neighborhood of

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residence. Table 11 shows that within each neighborhood, by far the great majority of respondents had not changed or thought of changing their doctors or clinics. In only one neighborhood, the Hill District, did the percentage who changed doctors or clinics vary by as much as 10% from that of any other neighborhood. Nevertheless, even in the Hill District, 88.4% of the families had not changed their regular source of treatment in the past year. Not only did the overwhelming majority of respondents in each neighborhood not change doctors or clinics, they also had not contemplated changing doctors or clinics, indicating by their comments they were satisfied with their present source of medical care. However, opinions on whether welfare patients were constrained in their choice of treatment source showed more substantial differences between respondents in the Hill District and those in the other two neighborhoods. More than one-quarter (28.6%) of the respondents in the Hill felt that welfare patients can get treatment only in certain places while percentages of those who felt this way in the other two neighborhoods were negligible, only 2.4% in South Oakland and 5.8% in Hazelwood. With respect to the equality of medical treatment for welfare patients, respondents in both the Hill District and South Oakland were much more likely than those in Hazelwood to feel that medical treatment for welfare patients was less good than that given to others. Slightly over one-third of the Hill respondents and slightly

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TABLE 11

VIEWS OF AVAILABLE HEALTH CARE BY NEIGHBORHOOD

Indicators		Hill %	South Oakland %	Hazelwood %
Changed doctors or clinics in past year	No	88.4	95.5	98.6
	Yes	11.6	4.5	1.4
	*N=(95)		(89)	(74)
Thought of changing doctors or clinics	No	87.2	86.7	100.0
	Yes	12.8	13.3	0.0
	N=(86)		(83)	(71)
Opinion on where welfare patients can go for treatment	Certain places only	28.6	2.4	5.8
	Anywhere	71.4	97.6	94.2
	N=(77)		(83)	(69)
Opinion on equality of treatment of welfare patients	Poorer	38.1	32.9	11.3
	Same	61.9	65.8	85.9
	Better	0.0	1.3	2.8
	N=(84)		(76)	(71)
Preferred source of treatment	Clinic	15.2	9.3	5.4
	Private doctor	45.7	59.3	21.6
	Emergency room	35.9	31.4	71.6
	Other	3.3	0.0	1.4
	N=(92)		(86)	(74)
Opinion on adequacy of health care in the community	Inadequate	32.2	10.1	58.9
	Adequate	67.8	89.9	41.1
	N=(87)		(79)	(73)

*Those who did not respond or who had no opinion were not included for analysis, hence the varying N's from item to item.

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under one-third of those in South Oakland felt this way compared to only 11.3% of respondents in Hazelwood who expressed a similar opinion.

Preferred source of medical treatment, however, presented a very mixed picture among the individual neighborhoods. The most notable and interesting finding in that regard was the difference between respondents in Hazelwood and those in the other two neighborhoods with respect to preference for private doctor and emergency room. Whereas nearly half the respondents in the Hill District (45.7%) and over half of those in South Oakland (59.3%) preferred private doctors to any other source of treatment, only 21.6% of Hazelwood respondents preferred a private doctor. However, fully 71.6% in Hazelwood indicated emergency room as their preferred source of treatment opposed to slightly more than one-third in the Hill District and slightly under one-third in South Oakland who so preferred. Thus, the results previously noted--that for the total study population nearly an equal proportion preferred emergency room as preferred a private doctor--were obviously tremendously skewed by respondents in Hazelwood. Similarly, on the general assessment of the adequacy of health care in ths community, almost 70% of respondents on the Hill felt it adequate, 90% of those in South Oakland felt so, but only about 40% of those in Hazelwood felt so. Were it not for respondents in Hazelwood (58.9% of whom felt that available

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health care was inadequate), the proportion of the total study population who felt health care in the community to be adequate would have been much higher than the 66.9% recorded on Table 10, page 78.

It would thus appear that residents in Hazelwood, who were found to have the highest utilization of health care, of whom 90.7% said they had a personal family physician, and almost all of whom neither changed nor contemplated changing their doctors or clinics were, despite this, the least satisfied in general with the health care available to them.

Part of the reason for this might be inherent in the fact that high utilization often provides the necessary ammunition for a negative assessment. This point was made by Richard Pomeroy in his study of the use of health services by families on welfare.[1] However, probably more importantly, Hazelwood is the neighborhood most isolated from the mainstream of medical care in Pittsburgh despite its physical proximity to the Health Center Hospitals of the University of Pittsburgh. To date, none of the hospitals has a special health care program in Hazelwood nor are there any operated by other agencies with the possible exception of a Planned Parenthood Clinic which has been an on-again,

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[1]See Richard Pomeroy, Studies in the Use of Health Services by Families on Welfare: Utilization by Publicly Assisted Families (New York: The Center for the Study of Urban Problems, 1969), p. 70.

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off-again proposition, and a Well-Baby Clinic operated by the Allegheny County Health Department. In addition there are only three doctors in full-time practice in the neighborhood and an additional one having limited office hours on Saturday only. Thus, most residents in Hazelwood who require treatment must seek it outside of their community. This presents an important problem to many who must use public transportation since the public transportation system is inadequate in that the only public bus service in Hazelwood requires a transfer and long waiting periods at transfer points. Also, those who use the doctors in the neighborhood must wait for long periods of time before being seen because of overcrowded patient loads. House calls are virtually nonexistent and the only emergency service is an overworked police emergency program which operates on a highly selective basis. Unfortunately, much of Hazelwood's difficulties is a result of its being the lowest priority poverty neighborhood.

Although from the foregoing it is clear that opinions of available health care expressed by the study population as a whole were without exception highly favorable, nevertheless some important differences in the general assessment of available health care exist among the individual neighborhoods. This emphasizes the importance of individual qualities of smaller residential units such as the neighborhood as influences on opinion. Such

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individuality is not only obscured in the aggregation of data, but it also tends to skew general findings.

The designation of a poverty area in no way suggests that it is socioeconomically or demographically homogeneous. Consequently, it was important to see whether the opinions expressed within each neighborhood and by the study population as a whole were shared equally by the different socioeconomic and demographic groups of which they are comprised. Four major socioeconomic and demographic classifications (race, age, education, and income) were subjected to cross-tabulation analysis with the selected opinion variables.

Views of Health Care by Race

Table 12 presents the opinion responses broken down by race considering whites and blacks only. This table shows that expressed views did not differ substantially between whites and blacks on most of the indicators. Opinions of both races were highly favorable. However, opinions of blacks were somewhat less favorable than those of whites on each indicator. On the two indicators concerned with discriminatory practices against welfare patients, the differential between the races was larger than on the other indicators. The percentage of blacks who felt that welfare patients are constrained in their choice of treatment was greater than such an opinion stated by whites by a 12.1 percentage point margin. Similarly, a

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TABLE 12

VIEWS OF AVAILABLE HEALTH CARE BY RACE

Indicators		White %	Black %
Changed doctors or clinics in past year	No	97.1	89.3
	Yes	2.9	10.7
		*N=(138)	(112)
Thought of changing doctors or clinics	No	93.9	87.1
	Yes	6.1	12.9
		N=(131)	(101)
Opinion on where welfare patients go for treatment	Certain places only	7.3	19.4
	Anywhere	92.7	80.6
		N=(123)	(98)
Opinion on equality of treatment of welfare patients	Poorer	18.5	37.6
	Same	79.0	62.4
	Better	2.4	0.0
		N=(124)	(101)
Preferred source of treatment	Clinic	8.1	13.0
	Private doctor	44.9	38.9
	Emergency room	46.3	45.4
	Other	0.7	2.8
		N=(136)	(108)
Opinion on adequacy of health care in the community	Inadequate	31.3	35.9
	Adequate	68.7	64.1
		N=(131)	(103)

*Those who did not respond or who had no opinion were not included for analysis, hence the varying N's from item to item.

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higher percentage of blacks than whites felt that medical treatment given welfare patients was of poorer quality than that given the rest of the population, a differential of 19.1 percentage points. Also, no blacks indicated that welfare patients get better treatment than others while 2.4% of whites so indicated. Blacks prefer clinics somewhat more than whites, private doctors somewhat less than whites, and emergency room in almost equal proportion to whites. There was only a small difference in their general assessment of overall adequacy of health care in the community, with a slightly lower percentage of blacks finding it adequate.

Thus, it appears that blacks, not unexpectedly in view of their higher proportion on welfare, were more inclined than whites to feel that welfare patients are subject to some discrimination. However, the significant finding was that, given their higher proportion on welfare and hence their proportionately greater experience as welfare patients, most blacks in the study population expressed favorable opinions.

Views by Race by Neighborhood

The foregoing discussion makes it clear that opinions among the study population as a whole relative to available health care are basically similar for both races. Within and among the individual neighborhoods, however, differences in opinions of available health care according

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to race were more substantial than those found in the total study population. Table 13 presents opinions of available health care by neighborhood and by race. On the first opinion indicator ("changed doctors or clinics in the past year") the difference between blacks and whites in the total population who had changed doctors was only 7.8% whereas in the Hill District the difference between the races in that regard was 13.3%, with blacks more likely than whites to have changed source of treatment. Racial differences in the other two neighborhoods were minimal--only 4.0% in South Oakland and 1.8% in Hazelwood. The differences in response among whites from one neighborhood to another was minimal, no more than 4.3%, whereas the differences among blacks from one neighborhood to another were much more substantial (13.3% between blacks living in the Hill District and those living in Hazelwood). Thus, all whites were very similar in their responses regardless of where they lived while responses of blacks in South Oakland and Hazelwood more closely resembled the responses of whites than those of blacks living in the Hill District.

On the second item in Table 13 ("thought of changing doctors or clinics") again a substantial difference between the races occurred among respondents in the Hill District where a 14.3% difference was found between blacks and whites. Blacks in the Hill were more likely to have changed doctors or clinics. Within the other two neighborhoods the differences between blacks and whites were 5.7%

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TABLE 13

VIEWS AVAILABLE HEALTH CARE BY RACE AND BY NEIGHBORHOOD

Indicators		Race					
		Hill		So.Oakland		Hazelwood	
		White %	Black %	White %	Black %	White %	Black %
Changed doctors or clinics in past year	No	100.0	86.7	95.7	91.7	98.2	100.0
	Yes	0.0	13.3	4.3	8.3	1.8	0.0
		*N=(12)	(83)	(69)	(12)	(57)	(17)
Thought of changing doctors or clinics	No	100.0	85.3	87.5	81.8	100.0	100.0
	Yes	0.0	14.7	12.5	18.2	0.0	0.0
		N=(11)	(75)	(64)	(11)	(56)	(17)
Opinion on where welfare patients can get treatment	Certain places only	37.5	27.5	3.2	0.0	7.7	0.0
	Anywhere	62.5	72.5	96.8	100.0	92.3	100.0
		N=(8)	(69)	(63)	(12)	(58)	(17)
Opinion on equality of treatment of welfare patients	Poorer	27.3	39.7	27.1	45.5	7.4	23.5
	Same	72.7	60.3	71.2	54.5	88.9	76.5
	Better	0.0	0.0	1.7	0.0	3.7	0.0
		N=(11)	(73)	(59)	(11)	(54)	(17)
Preferred source of treatment	Clinic	16.7	15.0	10.4	0.0	3.5	11.8
	Private doctor	58.3	43.8	58.2	54.5	26.3	5.9
	Emergency room	25.0	37.5	31.3	45.5	68.4	82.4
	Other	0.0	3.8	0.0	0.0	1.8	0.0
		N=(12)	(80)	(67)	(11)	(57)	(17)
Opinion on adequacy of health care in the community	Inadequate	30.0	32.5	9.2	11.1	57.1	64.7
	Adequate	70.0	67.5	90.8	88.9	42.9	35.3
		N=(10)	(77)	(65)	(9)	(56)	(17)

*Those who did not respond or who had no opinion were not included for analysis, hence the varying N's from item to item.

in South Oakland and there was no difference at all in Hazelwood. It was found that responses of whites in the Hill District and of whites and blacks in Hazelwood were exactly the same. All of them stated they had not contemplated changing their regular source of treatment. However, both whites and blacks in South Oakland were similar in their responses to blacks in the Hill District. Thus, with respect to changing or contemplating changing regular source of treatment there was no consistent pattern of response between the races within each neighborhood or within the same racial groups from neighborhood to neighborhood. This would appear to be a reflection of the individuality and uniqueness of each neighborhood which as an influence on views of its residents is as important a consideration as is race.

Racial differences within each neighborhood on the item concerning whether welfare patients are constrained in their choice of treatment sources did not vary much from one neighborhood to another. In the Hill District the differential between blacks and whites was 10%, while in South Oakland and Hazelwood it was 3.2% and 7.7% respectively. However, both blacks and whites in the Hill District were much more likely to have felt that welfare patients are constrained in their choices of treatment source than either blacks or whites in the other two neighborhoods. Over one-third of the whites and over one-quarter

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of the blacks in the Hill District felt this way in contrast to only 3.2% and 7.7% of the whites in South Oakland and Hazelwood respectively. None of the blacks in either of the latter neighborhoods expressed such an opinion. Again the influence of the particular neighborhood upon opinions can be seen regardless of the race of the respondent.

In each neighborhood blacks were more likely to have felt that the treatment received by welfare patients was not equal to that received by others. The differential between whites and blacks was similar in all neighborhoods: 12.4% in the Hill District, 18.4% in South Oakland, and 16.1% in Hazelwood. Yet, whites in the Hill District and South Oakland were almost equal in the percentage who felt medical treatment for welfare patients was poorer than that for others (27.3% in the Hill and 27.1% in South Oakland), while the percentage of whites in Hazelwood who felt this way was only 7.4%, a 20% differential between whites in this neighborhood and those in the other two. Similarly, blacks in the Hill, 39.7% of them, and in South Oakland, 45.5% of them, were closer to one another in their opinions of the equality of medical treatment offerred welfare patients than they were to blacks in Hazelwood where only 23.5% of them felt that way. Thus, both blacks and whites in Hazelwood were much less likely than blacks in the other two neighborhoods to have felt that welfare patients receive poorer treatment than others and were almost equal in that

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respect to whites in those other neighborhoods.

With regard to preferred source of treatment, blacks and whites in almost equal proportion in the Hill said they would prefer clinic, 16.7% of the whites and 15% of the blacks. In South Oakland, 10.4% of the whites preferred clinic and no blacks preferred clinics. In Hazelwood, blacks preferred clinics by a higher percentage than whites, 11.8% to 3.5%. However, in each of the neighborhoods a higher proportion of whites than blacks preferred private doctors. In the Hill the differential was 14.5%, in South Oakland the differential was minimal (only 3.7%), and in Hazelwood the differential was 20.4%. The reverse held true for those who preferred emergency room. A higher proportion of blacks than whites in each neighborhood preferred emergency room. The differential in the Hill was 12.5%, in South Oakland it was 14.2%, and in Hazelwood it was 14.0%. Thus, the degree of association between race and preference for emergency room was fairly similar within each neighborhood. Yet, there were important differences among the white group from one neighborhood to another and similarly among the black group from neighborhood to neighborhood. Whites in Hazelwood were much more likely to have preferred emergency room than whites in either the Hill or South Oakland. In fact, a majority of 68.4% of the whites in Hazelwood so preferred, whereas in the Hill the proportion was one-quarter and in South Oakland it was slightly

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less than one-third. Similarly, for blacks in Hazelwood a majority of 82.4% indicated a preference for emergency room, while in South Oakland 45.5% of the blacks so preferred and in the Hill 37.5% of the blacks so preferred. Although race was associated with preferred source of treatment within each neighborhood and therefore seemed to be a factor in determining opinions, nevertheless the particular neighborhood of residence appeared to be a strong influence on the preferences of those who reside within it, regardless of race.

With respect to the general assessment of the adequacy of health care in the community, the differential between the races was minimal within each neighborhood, only a 2.5% differential in the Hill, only a 1.9% differential in South Oakland, and a 7.9% differential in Hazelwood. In each neighborhood blacks were slightly more likely than whites to have felt health care in their community was inadequate. However, within each racial group from neighborhood to neighborhood, large differences were noted. Blacks in the Hill were almost three times more likely than blacks in South Oakland to have felt available health care was inadequate. Blacks in Hazelwood, a majority of whom felt health care was inadequate in their community, were twice as likely as blacks in the Hill to have so assessed available health care. Virtually the same differentials existed among whites from one neighborhood to another.

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Therefore, in terms of general assessment of the adequacy of health care in the community, the race of the respondent was not a factor in determining his views whereas the particular neighborhood in which he lived was extremely crucial in that regard.

To recapitulate, opinion differences between the races were observed within each neighborhood to varying degrees. Also, respondents of the same race but living in different neighborhoods varied considerably in their opinions. This again suggests the importance of where one lives as an influence on his views relative to available health care.

Views of Health Care by Age

Having explored the opinions of available health care as stratified by race among the total study population and within the individual neighborhoods of which it was comprised, we were interested to similarly explore these same opinions by the respondent's age. Table 14 shows very little differential among the three age cohorts on the first three opinion items ("changed doctors or clinics," "thought of changing doctors or clinics," and "where welfare patients can go for medical treatment"). On none of these items was there so much as a 7 percentage point differential among the different age groups.

However, when expressing their opinions on the fourth indicator (the equality of medical treatment for

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TABLE 14

VIEWS OF AVAILABLE HEALTH BY AGE

Indicators		Under 40 %	40-60 %	Over 60 %
Changed doctors or clinics in past year	No	90.1	95.3	96.6
	Yes	9.9	4.7	3.4
		*N=(81)	(106)	(59)
Thought of changing doctors or clinics	No	90.4	92.0	89.5
	Yes	9.6	8.0	10.5
		N=(73)	(100)	(57)
Opinion on where welfare patients can go for treatment	Certain places only	9.2	16.0	9.1
	Anywhere	90.8	84.0	90.9
		N=(76)	(100)	(44)
Opinion on equality of treatment of welfare patients	Poorer	47.1	21.0	20.4
	Same	52.9	77.0	77.6
	Better	0.0	2.0	2.0
		N=(70)	(100)	(49)
Preferred source of treatment	Clinic	8.9	3.8	21.1
	Private doctor	48.1	44.2	36.8
	Emergency room	41.8	51.0	40.4
	Other	1.3	1.0	1.8
		N=(79)	(104)	(57)
Opinion on adequacy of health care in the community	Inadequate	28.6	42.6	26.8
	Adequate	71.4	57.4	73.2
		N=(70)	(101)	(56)

*Those who did not respond or who had no opinion were not included for analysis, hence the varying N's from item to item.

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welfare patients), the youngest age group (under 40) was more than twice as likely as the other two age groups to have felt that treatment of welfare patients was of poorer quality than that given others and none in that age group indicated that medical treatment of welfare patients was better. Why this should have been so can only be speculated due to lack of specific data. It is possible, however, that since the youngest age group is comprised of families in the child-bearing years and because many of them are headed by females without a male counterpart in the home, they are the families most likely to be on welfare and consequently to have had the most experience as welfare patients leading to attitudes formed of actual experience. As noted earlier, it was suggested by Pomeroy that negative attitudes are more likely to result from more utilization than to serve as a deterrent to utilization.[2] Thus, increased experience with the medical welfare system may well lead to increased criticism of it. Nevertheless, a majority of 52.9% in this age group felt that welfare patients receive medical treatment equal to that received by others.

The fifth opinion item, on which respondents were requested to indicate which source of treatment they preferred (assuming they cost the same and were just as close), the oldest age group had the largest percentage preferring

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[2]Pomeroy, op. cit., p. 70.

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clinics, the smallest percentage preferring private doctors, and a percentage virutally equal to the youngest age group preferring emergency room. In the middle age group, however, a majority of 51.0% indicated a preference for treatment in the emergency room. Similarly, the middle age group was more likely than the other two age groups to have felt that health care in the community was inadequate. Little in the literature was found as a basis for speculating about the reasons for this picture on the last two items. However, Table 15, which presents opinions by neighborhood and by age, does offer some reasonable explanation. The reason was inherent in the differences found among the neighborhoods. Respondents in one of the neighborhoods, Hazelwood, were overwhelmingly negative in their assessment of available health care in every age group, and respondents in that neighborhood between the ages of 40 and 60 represented 39.6% of all respondents in that age group in the entire sample. Thus, the influence of respondents between ages 40 and 60 in Hazelwood heavily skewed the results toward a negative assessment of the adequacy of health care for the total population in that age group. Similarly, this age group in that neighborhood was overwhelming in its preference for emergency room treatment (79.5%) skewing the results in favor of a preference for emergency room care. This lends further support to the contention stated earlier, that much important and

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TABLE 15

VIEWS OF AVAILABLE HEALTH CARE BY AGE AND BY NEIGHBORHOOD

Indicators		Age								
		Hill			South Oakland			Hazelwood		
		Under 40 %	40-60 %	Over 60 %	Under 40 %	40-60 %	Over 60 %	Under 40 %	40-60 %	Over 60 %
Changed doctors or clinics in past year	No	86.4	85.3	93.8	90.7	100.0	100.0	93.8	100.0	100.0
	Yes	13.6	14.7	6.3	9.3	0.0	0.0	6.3	0.0	0.0
	*N=(22)		(34)	(32)	(43)	(32)	(10)	(16)	(40)	(17)
Thought of changing doctors or clinics	No	85.0	96.7	80.0	89.5	78.1	100.0	100.0	100.0	100.0
	Yes	15.0	3.3	20.0	10.5	21.9	0.0	0.0	0.0	0.0
	N=(20)		(30)	(30)	(38)	(32)	(10)	(15)	(38)	(17)
Opinion on where welfare patients can get treatment	Certain places only	21.1	41.9	19.0	2.4	3.2	0.0	13.3	5.3	0.0
	Anywhere	78.9	58.1	81.0	97.6	96.8	100.0	86.7	94.7	100.0
	N=(19)		(31)	(21)	(42)	(31)	(8)	(15)	(38)	(15)
Opinion on equality of treatment of welfare patients	Poorer	52.6	39.4	32.0	52.8	17.2	14.3	26.7	7.9	5.9
	Same	47.4	60.6	68.0	47.2	79.3	85.7	73.3	89.5	88.2
	Better	0.0	0.0	0.0	0.0	3.4	0.0	0.0	2.6	5.9
	N=(19)		(33)	(25)	(36)	(29)	(7)	(15)	(38)	(17)
Preferred source of treatment	Clinic	14.6	0.0	30.0	7.3	9.4	11.1	6.3	2.6	11.1
	Private doctor	36.4	63.6	36.7	63.4	56.3	55.6	25.0	17.9	27.8
	Emergency room	50.0	33.3	30.0	29.3	34.4	33.3	62.5	79.5	61.1
	Other	0.0	3.0	3.3	0.0	0.0	0.0	6.3	0.0	0.0
	N=(22)		(33)	(30)	(41)	(32)	(9)	(16)	(39)	(18)
Opinion on adequacy of health care in the community	Inadequate	36.8	53.1	13.8	10.8	10.3	11.1	64.3	57.5	55.6
	Adequate	63.2	46.9	86.2	89.2	89.7	88.9	35.7	42.5	44.4
	N=(19)		(32)	(29)	(37)	(29)	(9)	(14)	(40)	(18)

*Those who did not respond or who had no opinion were not included for analysis, hence the varying N's from item to item.

often unique information with respect to a particular community is lost in the aggregation of data. It will be recalled from Table 10, page 78, that among the total population, less than half (44.8%) preferred emergency room treatment to all other forms while for respondents in Hazelwood the percentage was fully 71.6% who so responded. Similarly, among the total study population, 66.9% expressed the opinion that health care in their community was adequate, but among respondents in Hazelwood, only 41.1% felt that was so. Among residents in the other two neighborhoods, the Hill District and South Oakland, only 35.9% and 31.4% respectively preferred emergency room as a source of treatment, while 67.8% and 89.9% respectively felt that health care in their community was adequate. It would seem obvious from this that planning with these neighborhoods would require different points of departure and would necessitate quite different approaches in an attempt to involve residents in any planning efforts.

Views by Age by Neighborhood

This conclusion gains additional support when Table 15 is again consulted. From the table it is clear that within each neighborhood the opinion differences among the three age groups on the first item did not vary very much. There was only an 8.5% spread in the Hill, a 9.3% spread in South Oakland, and a 6.2% spread in Hazelwood. Similarly, within each age group from one neighborhood to

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the next there was very little differential in the percentage having changed doctors or clinics with one exception. The differential between the 40-60-year-old group in the Hill District and those in the same age group in the other two neighborhoods was 14.7%. Nevertheless, the overall impression was that there was very little differential among different age groups within the individual neighborhoods or among those in the same age group from neighborhood to neighborhood.

For those having contemplated changing doctors or clinics, a mixed picture emerged among the age groups within each community. In the Hill the oldest and youngest groups were more likely than the middle age group to have considered changing their source of treatment. The average differential among all age groups in the Hill was 11.1%. In South Oakland, however, the middle age group was more likely than both the oldest and youngest groups to have considered changing their regular source of treatment, the reverse of the situation in the Hill District. The average differential among all age groups in South Oakland was 14.6%, not much different from the 11.1% average differential in the Hill. In Hazelwood all respondents in all age groups had not contemplated changing physicians. From neighborhood to neighborhood within each age group an ambiguous picture emerged. The youngest groups in the Hill and South Oakland were closer to each other in their

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responses than they were to the same age group in Hazelwood. However, for the middle age groups those in the Hill and in Hazelwood resembled one another in their responses while this same age group in South Oakland differed from them by an average of 20.3%. For the oldest group a still different pattern was noted from neighborhood to neighborhood. Where the oldest group in South Oakland and that in Hazelwood responded exactly alike, that in the Hill was separated from them by 20%. A similar ambiguous pattern with respect to opinions on where welfare patients can go for treatment was found among the age groups within each neighborhood and within each age group from one neighborhood to another. In South Oakland the differences among the age groups were minimal with almost all respondents in all age groups having indicated that welfare patients were not constrained in their choice of source of treatment. In Hazelwood the largest difference was between the oldest and youngest age group (13.3%), where the youngest group was more likely to have felt that welfare patients are limited in their choice of treatment source. Nonetheless, the great majority in each age group was of the opinion that welfare patients had no such constraints. In the Hill, however, the oldest and youngest groups were very similar to one another in their opinion that welfare patients are not constrained in their choice of treatment source while the middle age group in the Hill was much more likely than the other two age groups in

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in their neighborhood, or than any age group in either of the other neighborhoods, to have felt that choice of treatment source was limited for welfare patients. Within each age group there were substantial response differences from one neighborhood to another.

With respect to opinions on the equality of medical care received by welfare patients, the differentials among the age groups within each neighborhood were fairly substantial. The differential in the Hill averaged 13.5%, in South Oakland the average differential was 25.7%, and in Hazelwood it was 20.8%. In each neighborhood the middle and oldest age groups were less likely than the youngest age group to have felt that welfare patients got poorer treatment than others. Within each age group from neighborhood to neighborhood there were for the most part substantial differences. The youngest age groups in the Hill and South Oakland were nearly twice as likely as the same age group in Hazelwood to have felt that welfare patients received poorer treatment. The middle age group in the Hill was almost twice as likely as that in South Oakland--which was twice as likely as that age group in Hazelwood--to have felt welfare patients got poorer treatment than others. A similar differential in that respect obtained within the oldest age group from one neighborhood to another.

The foregoing discussion presented a very complex, ambiguous, unpatterned picture of opinions of available

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health care by age and by neighborhood, thus making specific interpretations impossible. Yet this very complexity suggests that each neighborhood is individual and has certain characteristics which make it unique.

Views of Health Care by Education

The total study population, when stratified for education of the female head of the household, yielded the results shown on Table 16. On the first two attitude indicators ("changed . . ." or "thought of changing doctors or clinics") the differential among the three education classifications was minimal, not as much as 6%. The third attitude indicator ("where welfare patients can go for medical treatment") also showed a relatively small differential among the education groups, only 8.7% between those with the highest education and those with the lowest education. However, a fairly substantial difference was noted between the group having the highest education and the other two education classifications on their views concerning the equality of medical treatment received by welfare patients. Slightly over half, 52.0%, of those in the highest education group thought that welfare patients get poorer medical treatment than others while slightly under one-quarter of the lowest education group, 23.9%, felt that this was so. It is likely that the views of the most educated concerning treatment of welfare patients are born of their more sophisticated knowledge and awareness from having read of problems confronting

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TABLE 16

VIEWS OF AVAILABLE HEALTH CARE BY EDUCATION

Indicators		Under 9 Years %	9 - 12 Years %	Over 12 Years %
Changed doctors or clinics in past year	No	97.4	91.7	93.9
	Yes	2.6	8.3	6.1
	*N=(78)		(132)	(33)
Thought of changing doctors or clinics	No	89.3	91.0	93.3
	Yes	10.7	9.0	6.7
	N=(75)		(122)	(30)
Opinions on where welfare patients can get treatment	Certain places only	7.4	14.2	16.1
	Anywhere	92.6	85.8	83.9
	N=(68)		(120)	(31)
Opinion on equality of treatment of welfare patients	Poorer	23.9	27.8	52.0
	Same	76.1	69.8	48.0
	Better	0.0	2.4	0.0
	N=(67)		(126)	(25)
Preferred source of treatment	Clinic	18.7	6.2	0.0
	Private doctor	30.7	44.6	69.7
	Emergency room	49.3	47.7	30.3
	Other	1.3	1.5	0.0
	N=(75)		(130)	(33)
Opinion on adequacy of health care in community	Inadequate	33.3	36.0	33.3
	Adequate	66.7	64.0	66.7
	N=(69)		(125)	(30)

*Those who did not respond or who had no opinion were not included for analysis, hence the varying N's from item to item.

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people on welfare. Also, it is likely that their frame of reference relative to medical care is oriented to the concept of fee-for-service and the private doctor-patient relationship. Thus, a treatment source, self-selected and self-paid, is better by comparison to one which entails a forced choice and is either free of charge or paid for from public funds. Some evidence to support this interpretation can be seen on the previous indicator, "where welfare patients can go for medical treatment," where the most educated group was somewhat more likely than the others to feel that welfare patients are constrained in their choice of treatment facilities. Also, on the following indicator, "preferred source of treatment," the most educated group showed a preference for treatment by a private doctor by a substantial majority of 69.7% while much smaller percentages of those in the other two education groups preferred private doctors, 30.7% and 44.6% for the lowest and middle education groups respectively. The association between preferred source of treatment and education is fairly strong. The higher the educational level the more likely the preferred source of treatment will be a private physician, the less likely will it be clinics or emergency room.

Although differences of opinion among the various educational levels were noted with respect to equality of medical treatment for welfare patients and preferred source of treatment, virtually no difference was found among them

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in their general assessment of the adequacy of health care in their community. A substantial and almost equivalent majority in each educational level felt health care in their community to be adequate.

Views by Education by Neighborhood

Opinions of available health care by education stratified also for neighborhood are shown on Table 17. Among the various educational levels within each neighborhood minimal differentials were found in the percentage of those who had not changed doctors or clinics in the past year. Similarly, within each of the education classifications there was little variation in the responses from one neighborhood to another. Thus, neither education nor the neighborhood of residence had any particular bearing on whether or not respondents changed doctors or clinics. The compelling majority of respondents had not changed its source of treatment regardless of its education or place of residence. Similarly, regardless of education or neighborhood of residence, the overwhelming majority had not contemplated such a change. The only neighborhood in which the average differential among the different educational levels was even 10% was the Hill. Within each level of education from one neighborhood to another, the differences among the respondents were also not very substantial.

With respect to opinions relative to the constraints on the choice of treatment sources for welfare patients, it

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TABLE 17

VIEWS OF AVAILABLE HEALTH CARE BY EDUCATION BY NEIGHBORHOOD

Indicators		Education								
		Hill			South Oakland			Hazelwood		
		Under 9 years %	9-12 %	Over 12 %	Under 9 yrs %	9-12 %	Over 12 %	Under 9 yrs %	9-12 %	Over 12 %
Changed doctors or clinics in past year	No	97.0	80.0	100.0	94.7	97.6	90.9	100.0	100.0	100.0
	Yes	3.0	20.0	0.0	5.3	2.4	9.1	0.0	0.0	0.0
	*N=	(33)	(45)	(9)	(19)	(42)	(22)	(25)	(43)	(2)
Thought of changing doctors or clinics	No	81.3	89.5	100.0	88.9	82.9	89.5	100.0	100.0	100.0
	Yes	18.7	10.5	0.0	11.1	17.1	10.5	0.0	0.0	0.0
	N=	(32)	(38)	(9)	(18)	(41)	(19)	(26)	(44)	(2)
Opinion on where welfare patient can get treatment	Certain places only	15.4	34.2	57.1	0.0	2.4	4.5	3.8	7.5	0.0
	Anywhere	84.6	65.8	42.9	100.0	97.6	95.5	96.2	92.5	100.0
	N=	(26)	(38)	(7)	(16)	(42)	(22)	(26)	(40)	(2)
Opinion on equality of treatment of welfare patients	Poorer	44.0	40.9	28.6	25.0	27.5	62.5	3.8	14.3	50.0
	Same	56.0	59.1	71.4	75.0	70.0	37.5	96.2	81.0	50.0
	Better	0.0	0.0	0.0	0.0	2.5	0.0	0.0	4.8	0.0
	N=	(25)	(44)	(7)	(16)	(40)	(16)	(26)	(42)	(2)
Preferred source of treatment	Clinic	22.6	9.1	0.0	22.2	7.3	0.0	11.5	2.2	0.0
	Private doctor	35.5	50.0	77.8	44.4	58.5	72.7	15.4	26.7	0.0
	Emergency room	38.7	38.6	22.2	33.3	34.1	27.3	73.1	68.9	100.0
	Other	3.2	2.3	0.0	0.0	0.0	0.0	0.0	2.2	0.0
	N=	(31)	(44)	(9)	(18)	(41)	(22)	(26)	(45)	(2)
Opinion on adequacy of health care in the community	Inadequate	17.9	40.5	66.7	13.3	10.3	10.5	61.5	54.5	100.0
	Adequate	82.1	59.5	33.3	86.7	89.7	89.5	38.5	45.5	0.0
	N=	(28)	(42)	(9)	(15)	(39)	(19)	(26)	(44)	(2)

*Those who did not respond or who had no opinion were not included for analysis, hence the varying N's from item to item.

was found that large differences among the various educational levels existed in the Hill while in South Oakland and Hazelwood such differences were minimal. In the Hill District it was found that the proportion of those who felt that welfare patients were constrained in their choice of treatment source increased with education. Those having the highest education were almost four times as likely as those having the lowest education to have felt that welfare patients were limited in their choice of treatment source (57.1% in the highest education classification as opposed to 15.4% in the lowest education classification). Those having completed between 9 and 12 years of education were twice as likely as those having completed under 9 years of education to have felt that way. Despite the fact that differentials among the various educational levels in South Oakland were minimal, such variation as was noted followed the same pattern as was described for the Hill: the more education the higher proportion felt that welfare patients were limited in where they could go for treatment. The same held true for Hazelwood with the exception of those having the highest education, none of whom felt this way. However, it is not possible to infer much about those with over 12 years of education in Hazelwood because there were only two such residents in the sample.

The assessment of the equality of medical treatment given to welfare patients relative to others showed some

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variations within the neighborhoods in the responses of the different educational levels. In the Hill District, those having under 9 years and those having between 9 and 12 years of education were almost alike in their porportion who assessed as poorer the medical treatment given to welfare patients (44.0% and 40.9% respectively), while of the group having over 12 years of education the porportion who were of that opinion was much lower, 28.6%. Within South Oakland, as in the Hill, little difference was found between the under 9 year and the 9 to 12 year educational levels in the proportion who felt welfare patients get poorer medical treatment than others (25.0% and 27.5%). However, unlike in the Hill, a substantial majority of 62.5% of those in South Oakland having the highest education assessed the medical treatment given welfare patients as relatively poorer than that provided others. Within Hazelwood a still different picture emerged relative to the association between education and the assessment of the equality of treatment for welfare patients. In this neighborhood the proportion of those having between 9 and 12 years of education who gave a poorer assessment of medical treatment of welfare patients was almost three times that of those having under 9 years of education. The proportion of those having the highest education who so assessed was over three times that of those having between 9 and 12 years of education. Again, it must be remembered that the highest education

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group in Hazelwood was comprised of only two people.

Within each neighborhood, therefore, the association between education and assessment of the equality of medical treatment of welfare patients varied considerably and inconsistently. Also, there were tremendous response variations among those in the same education contingent who lived in different neighborhoods. This suggests that although peoples' education has some bearing on their opinions, its influence is affected considerably by the particular neighborhood in which they live.

With respect to preferred sources of treatment, it was found that within each neighborhood the more educated the respondent, the less likely was she to have preferred clinics, the more likely was she to have preferred private doctors, and the less likely was she to have preferred emergency room. The respondents in Hazelwood having the highest education were notable excepticns to this trend, but again this was essentially meaningless because there were only two people in the sample from that neighborhood who had more than 12 years of education.

Although within the neighborhoods education was associated with preferred source of treatment, there were large differentials among respondents within the same education classification who resided in different neighborhoods.

The general assessment of adequacy of health care in the community among the different levels of education

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within each neighborhood also presented an inconsistent picture. In the Hill District the proportion holding the opinion that available health care in the community was inadequate was greater with each advancing level of education. In South Oakland the proportions among the different educational levels who felt available health care to be inadequate were almost equal. In Hazelwood, eliminating the highest educational level from consideration because of the insufficient number, a higher proportion of those having the least education than those having between 9 and 12 years of education felt that available health care in the community was inadequate.

Within each educational level from one neighborhood to another the proportions who felt available health care to be inadequate varied considerably again showing the strong influence of the particular neighborhood of residence upon opinions even among people on the same educational level.

Views of Health Care by Income

Despite the complex multi-faceted face of poverty, its most salient characteristic is low income. Given the weight of evidence in the literature concerning how badly low-income groups come off relative to others with respect to health and health care, one might expect that their views toward available health care would be essentially negative or at least less positive than those in higher

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income groups. Yet, the Louis Harris survey cited earlier did show that there was little difference between the views of the affluent and those of the poor in their assessment of available health care. In our study population we found essentially the same thing. Table 18 shows the views toward available health care among the total study population stratified for income. On the first four opinion items only minimal differences from one income group to another were observed. In no case did the differential go as high as 7% from one income group to another. On the fifth indicator ("preferred source of treatment") the lowest income group (under $4,000 per year) was more likely than the other income groups to have preferred clinics as a source of treatment and less likely than the others to have preferred private doctors. Differences between the middle and upper income groups in that regard were minimal. Surprisingly, however, all the income groups had similar percentages preferring emergency room as a treatment source. Why the middle and upper income groups should have indicated a preference for the emergency room in the same proportion as those in the lowest income group was again a result of the respondents residing in Hazelwood who skewed the results heavily in favor of emergency room. Respondents in Hazelwood in the over $8,000 category represented 37.3% of all respondents in that income group and 68.4% of them preferred emergency room compared with only 35.0% and 16.7% in South

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TABLE 18

VIEWS OF AVAILABLE HEALTH CARE BY INCOME

Indicators		Under $4,000 %	$4,000-$8,000 %	Above $8,000 %
Changed doctors or clinics in past year	No	91.4	93.3	98.1
	Yes	8.6	6.7	1.9
		*N=(116)	(75)	(53)
Thought of changing doctors or clinics	No	88.7	94.3	90.2
	Yes	11.3	5.7	9.8
		N=(106)	(70)	(51)
Opinion on where welfare patients can get treatment	Certain places only	11.8	10.0	15.2
	Anywhere	88.2	90.0	84.8
		N=(102)	(70)	(46)
Opinion on equality of treatment of welfare patients	Poorer	30.8	27.3	26.0
	Same	69.2	71.2	72.0
		0.0	1.5	2.0
		N=(104)	(66)	(50)
Preferred source of treatment	Clinic	19.1	2.7	3.9
	Private doctor	33.0	50.0	52.9
	Emergency room	46.1	45.9	43.1
	Other	1.7	1.4	0.0
		N=(115)	(74)	(51)
Opinion on adequacy of health care in the community	Inadequate	29.9	44.3	30.6
	Adequate	70.1	55.7	69.4
		N=(107)	(70)	(49)

*Those who did not respond or who had no opinion were not included for analysis, hence the varying N's from item to item.

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Oakland and the Hill respectively. Similarly, they represented 31.3% of respondents in the $4,000-$8,000 income range and 78.3% of them preferred emergency room compared with only 25.0% and 42.1% in South Oakland and the Hill respectively. The influence of respondents in Hazelwood can also be seen on the last indicator where the middle income group was considerably less favorable in their general assessment of the adequacy of health care available in the community than were the other two income groups. As noted above, Hazelwood respondents in the $4,000-$8,000 income range represented 31.3% of all respondents in that income category and 78.3% of them felt health care in their community to be inadequate, compared with only 10.3 and 55.6% in South Oakland and the Hill respectively. Again it becomes clear how important information about a particular community can be lost in the aggregation of data.

Views by Income by Neighborhood

Within the individual neighborhoods, as revealed in Table 19, income as it was associated with the various opinion items revealed essentially the same mixed pattern as was noted with the race, age, and education variables. With respect to having changed or not changed doctors or clinics, in no neighborhood was the average differential among the various income groups as high as 6%. Similarly, within each income group from one neighborhood to another only the difference between the lowest income group in the

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TABLE 19

VIEWS OF AVAILABLE HEALTH CARE BY YEARLY INCOME AND BY NEIGHBORHOOD

Indicators		Income (in thousands)								
		Hill			South Oakland			Hazelwood		
		Under 4 %	4 - 8 %	Over 8 %	Under 4 %	4 - 8	Over 8 %	Under 4 %	4 - 8 %	Over 8 %
Changed doctors or clinics in past year	No	86.7	89.5	92.3	92.3	93.9	100.0	100.0	95.7	100.0
	Yes	13.3	10.5	7.7	7.7	6.1	0.0	0.0	4.3	0.0
	*N=	(60)	(19)	(13)	(26)	(33)	(20)	(30)	(23)	(20)
Thought of changing doctors or clinics	No	83.0	94.7	91.7	87.5	90.0	78.9	100.0	100.0	100.0
	Yes	17.0	5.3	8.3	12.5	10.0	21.1	0.0	0.0	0.0
	N=	(53)	(19)	(12)	(24)	(30)	(19)	(29)	(21)	(20)
Opinion on where welfare patient can get treatment	Certain Places only	24.0	23.5	62.5	0.0	0.0	5.3	0.0	14.3	5.3
	Anywhere	76.0	76.5	37.5	100.0	100.0	94.7	100.0	85.7	94.7
	N=	(50)	(17)	(8)	(24)	(32)	(19)	(28)	(21)	(19)
Opinion on equality of treatment of welfare patients	Poorer	36.5	38.9	36.4	34.8	38.5	35.0	17.2	4.5	10.5
	Same	63.5	61.1	63.6	65.2	61.5	60.0	82.8	90.9	89.5
	Better	0.0	0.0	0.0	0.0	0.0	5.0	0.0	4.5	0.0
	N=	(52)	(18)	(11)	(23)	(26)	(20)	(29)	(22)	(19)
Preferred source of treatment	Clinic	24.1	0.0	0.0	19.2	6.3	5.0	9.7	0.0	5.3
	Private doctor	32.8	57.9	83.3	46.2	68.8	60.0	22.6	17.4	26.3
	Emergency room	39.7	42.1	16.7	34.6	25.0	35.0	67.7	78.3	68.4
	Other	3.4	0.0	0.0	0.0	0.0	0.0	0.0	4.3	0.0
	N=	(58)	(19)	(12)	(26)	(32)	(20)	(31)	(23)	(19)
Opinion on adequacy of health care in the community	Inadequate	21.8	55.6	50.0	9.5	10.3	10.5	58.1	78.3	38.9
	Adequate	78.2	44.4	50.0	90.5	89.7	89.5	41.9	21.7	61.1
	N=	(55)	(18)	(12)	(21)	(29)	(19)	(31)	(23)	(18)

*Those who did not respond or who had no opinion were not included for analysis, hence the varying N's from item to item.

Hill and that in Hazelwood exceeded 10% and that difference was only 13.3%. Thus, neither neighborhood of residence nor income were particularly important determinants in whether or not respondents changed treatment source in the past year. In fact, in all income groups in every neighborhood the overwhelming majority had not changed doctors.

With some modifications, the same held true generally with respect to whether or not respondents thought of changing doctors or clinics in the past year. In no neighborhood was the differential among the income groups as high as 8%. However, more substantial differences were found within income groups from one neighborhood to another, but there was no consistent pattern to the variations thereby defying any logical interpretation. However, the fact that those in the same income classification but living in different neighborhoods responded substantially differently is indicative of the unique circumstances within the particular neighborhood which tend to influence the opinions of those who reside therein regardless of their income.

Further differentials among the neighborhoods were found with respect to the opinions of various income groups within them as to whether or not welfare patients were limited in their choice of treatment facilities. In the Hill District, a majority of 62.5% in the highest income classification were of the opinion that welfare patients were subject to such limitations while the middle and lowest

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income groups were nearly equal in the percentage who were of that opinion, 23.5% and 24.0% respectively. In South Oakland, however, differences among the income groups were minimal. No one in the middle and lowest income groups felt that welfare patients were constrained in their choice of treatment source, and only 5.3% in the highest income group were of that opinion. Respondents in Hazelwood were similar to those in South Oakland in that only a small minority in any income group felt that welfare patients were constrained in their choice of treatment source. The only difference in that regard between respondents in Hazelwood and those in South Oakland was that the middle income group in Hazelwood (versus the lowest income group in South Oakland) had the highest percentage within that neighborhood who felt that welfare patients were limited in their choice of treatment source.

Within each income group from one neighborhood to another the differences were dramatic, especially between the Hill District and the other two neighborhoods. The proportion in each income group in the Hill who felt welfare patients were constrained in their choice of treatment source was considerably higher than of those in the same income groups in either of the other two neighborhoods. Again, this suggests the uniqueness of individual neighborhoods and the importance of this as an influence on opinions.

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With regard to the assessment of the equality of medical treatment given welfare patients, there was little differential among the various income groups within each neighborhood. A substantial majority in each income group in each neighborhood felt that health care provided welfare patients was at least equal to that given others. Within the Hill District and South Oakland the proportions who assessed the medical care given to welfare patients to be inadequate were just about equal for all three income levels. In Hazelwood there were differences among the income groups, but for the most part they were small and not terribly important while considering that the proportion within each income group in Hazelwood who assessed medical care of welfare patients as at least equal to that of others was considerably higher than it was for the same income groups in the other neighborhoods. Thus, within each neighborhood, income had little bearing on opinions regarding the equality of medical treatment for welfare patients. However, a substantial difference was observed among those in the same income group in the different neighborhoods, especially between respondents in the Hill and South Oakland, who were alike regardless of income, and those in Hazelwood.

Preferred sources of treatment showed a mixed configuration among the different income groups within each neighborhood. In each neighborhood a higher proportion in the lowest income group than in either of the other two

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income classifications preferred clinics. With respect to a preference for private doctor, in the Hill District the proportion of those who so preferred increased substantially with each advancing level of income. Whereas only 32.8% in the lowest income group preferred private doctors, 83.3% in the highest income group had such a preference. In South Oakland, the association between income level and preference for a private physician was less clear. Although a lower proportion in the lowest income group than in either of the other two income groups preferred private doctors, the difference between the middle and highest income groups was not particularly large and the highest income group had a lower proportion than the middle income group who preferred private doctors. In Hazelwood, yet a different picture emerged. All the income groups in Hazelwood were much closer to one another in their proportion who preferred private doctors than were the different income groups in either of the other neighborhoods. Only 8.9 percentage points separated the middle income group (who had the lowest proportion preferring private doctors) from the highest income group (who had the highest percentage who so preferred) with an average differential among all three income groups of only 5.9%. From neighborhood to neighborhood substantial differences were found within each income classification. The above presents additional evidence in support of the proposition that the neighborhood in which

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one lives is a crucial factor in opinions with respect to available health care regardless of income. Similar evidence for this was found in the differences among income groups within the neighborhoods and from neighborhood to neighborhood among those who preferred emergency room and also in their general assessment of the adequacy of health care in the community.

Summary

In this chapter we explored the views of the study population relative to available health care employing six items as opinion variables. The first two items "changed . . ." or "thought of changing doctors or clinics" were employed to assess the satisfaction of respondents with their regular source of treatment. The next two items, "where welfare patients can get treatment" and the "equality of treatment of welfare patients," explored the views of the study population relative to discriminatory practices against an identifiable low-income group. The fifth item, "preferred source of treatment" was employed to explore where people in the study population would prefer to go for treatment assuming barriers of cost and accessibility were removed. The sixth, and last item, "adequacy of health care in the community," called for a general personal assessment of health care available in the community.

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The findings revealed that a substantial majority in the total study population held favorable views of available health care as reflected by their responses on all six opinion items employed. The neighborhood in which respondents lived was found to be an important factor influencing the views of those residing within it as reflected by substantial response differences among residents in the different neighborhoods. Although the total population when stratified for socioeconomic and demographic variables revealed differences among the contingent race, age, education, and income categories, such differences appeared to be as much a function of the particular neighborhood of residence as it was of race, age, education, or income. Evidence to support that contention was found when opinions of the respondents were analyzed by race, age, education, and income, separately controlling for neighborhood of residence in each case. The relationship between the socioeconomic and demographic variables within each neighborhood showed little consistency, and there were large response differentials among those in the same socioeconomic and demographic contingent groups from one neighborhood to another. This suggested that regardless of the race, age, education, or income of respondents, their views of available health care were influenced in large measure by the neighborhood in which they lived.

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CHAPTER V

NEIGHBORHOOD VARIATIONS: A THEORETICAL FRAMEWORK

This study found that there were important differences among residents in three local contiguous poverty neighborhoods with respect to their utilization of health services and their views of available health care. Further, it was found that such differences were not explained by the variables of race, age, education, and income which have generally been found throughout the literature to be importantly associated with health and utilization of health care. Two observations relative to the differences among the communities with respect to both utilization of health services and views of available health care stand out. In the first place, within each of the neighborhoods, for the most part, the degree and direction of association between both utilization of health services and views of available health care and the socioeconomic and demographic variables differed from one neighborhood to another. Sometimes such differences existed among all three neighborhoods and occasionally the differences were between a single neighborhood and the other two. Secondly, on a number of indicators major variations were not observed within the neighborhoods in the association between the socioeconomic and demographic variables and the utilization and opinion variables.

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However, from one neighborhood to another, there were important variations within contingent groups of the socio-economic and demographic variables.

This suggested that whatever influence race, age, education, or income might be on utilization of health services and opinions of available health care, influences of the particular neighborhood of residence are stronger. This would seem to indicate that regardless of socioeconomic status or demographic characteristics something within the ethos of a particular neighborhood operates to affect its residents' utilization of health services and their views of available health care. To have determined this in no way suggests what in the ethos of the neighborhood operates in this way and the study data do not in any way shed any light on this important issue.

Thus, possible answers to this must be sought in those theoretical concepts which have some relevance to neighborhoods. The purpose of this chapter is to attempt to bring together some of this theory in such a way as to provide a theoretical framework within which an explanation of the variation among residents in different neighborhoods might be sought in the context of their differing ethos.

Theoretical Framework

This social system model of societal structure views society as a collectivity of many subsystems which are

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interdependent upon one another in an effort to maintain a degree of unity and stability of the whole.[1] To maintain such unity and stability a body of commonly held values and goals is developed. Such commonly held values and goals are superimposed and supersede the individual and different values and goals among the various subsystems of which society is comprised.

Similarly, every community is itself viewed as a society[2] and as such is also in the words of Moe:

> A social system or "patterned interaction" in which certain elements such as goals, norms, roles and authority-power are observable, and in which certain basic processes such as communication, decision making, systemic linkage, and boundary maintenance are operating.[3]

The boundary maintenance function of community is expanded by Schmandt and Goldbach who note:

> Aside from the question of shared values, the traditional mark of the community, people and groups in urban settlements are united by the interdependence which arises among them as they pursue their diverse interests in a common locality. This dependency on one another gives rise to a mutual concern among urbanites in maintaining the operation of their

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[1]David M. Austin, "Influence of Community Setting on Neighborhood Action" in John B. Turner (ed.), Neighborhood Organization for Community Action (New York: National Association of Social Workers, 1967), p. 77.

[2]Blaine E. Mercer, "Community Functions" in Roland Warren (ed.), Perspectives on the American Community (Chicago: Rand McNally & Co., 1966), p. 533.

[3]Edward O. Moe, "The Nature of a Community," in Bennis, Benne, and Chin (eds.), The Planning of Change (New York: Holt, Rinehart, and Winston, 1966), p. 400.

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place-based systems.[4]

Thus community is the common occupation of a geographic space, the purpose of which is to meet common needs which arise from such sharing, and in the process of meeting such needs certain characteristic modes of action are developed.[5] To the extent a neighborhood meets these criteria, it is a community as Cunningham states:

> No matter what the location, if lives of people and institutions are interwoven, if essential human needs are served and links to the metropolis provided, then it is a neighborhood community. If not it is not a community but a residential section.[6]

In order to assure the viability of the community, those who reside within it must be socialized to the set of values and goals which are to be commonly pursued. They must learn the behavior expected of them and what they can expect of others. Although some of this is learned through the formal institutions such as schools, churches, organizations, and agencies within the community, a substantial portion is learned through the informal day-to-day interactions in primary groups:

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[4]Henry J. Schmandt and John C. Goldbach, "The Urban Paradox" in Schmandt and Bloomberg (eds.), The Quality of Urban Life (Urban Affairs Annual Review, III; Beverly Hills, California: Sage Publications, 1969), p. 478.

[5]Albert J. Reiss, Jr., "The Sociological Study of Communities," in Roland Warren (ed.), Perspectives on the American Community (Chicago: Rand McNally and Co., 1966), p. 595.

[6]James V. Cunningham, The Resurgent Neighborhood (Notre Dame, Indiana: Fides Publishers, Inc., 1965), p. 25.

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> Adult's life in his community of residence brings him into recurrent interaction with his friends, members of his social clubs, the church, school, political parties, action groups, volunteer organizations, and other groups which constitute the structure of the community. An adult participating in community life will be confronted with prescription for his behavior . . . .[7]

In this respect Cooley considers the neighborhood itself as a primary group characterized by intimate face-to-face associations and cooperation:

> . . . [primary groups are] fundamental in forming the social nature and ideals of the individual. The result of intimate association, psychologically, is a certain fusion of individualities in a common whole so that one's self, for many purposes at least, is the common life and purpose of the group. It involves the sort of sympathy and mutual identification for which "we" is the natural expression of the neighborhood group it may be said, in general, it has played a main part in the primary, heart-to-heart life of the people.[8]

In essence the close interaction of people in a community brings to bear a powerful force of interpersonal influence which organizes and guides their behavior and perceptions in accordance with prescribed community norms and values. As Wilson states:

> The way he [an individual] behaves will, ideally, alter the behavior of others . . . . [What he does and says] not only express what the individual thinks is appropriate conduct, but in some degree influence what his neighbors take to be appropriate

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[7]Orvill G. Brim, Jr., "Adult Socialization," in John A. Clausen (ed.), Socialization and Society (Boston: Little, Brown & Co., 1968), p. 214.

[8]Charles H. Cooley, "Primary Groups," in Parsons, Shils, Naegele, and Pitts (eds.), Theories of Society (New York: Free Press, 1961), pp. 315-316.

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conduct.[9]

According to Freidson, such influence of the local social networks rests on sympathy and shared experience creating a tradition which is channeled and sustained by informal and intimate modes of communication such as word of mouth, small social groups, committees, etc.[10] He further states that "channels of influence and authority [in a community] exist independently of the profession which guides patients toward or away from utilization [of health care]."[11] Consequently, as a social actor, an individual's response to a given social situation will be related to the preexisting common practice extant in his neighborhood and is learned through participation in the local community. However, as Greer points out:

> While social character is a major basis for commonality in a social collective, it is more. Unlike the common culture, it points to patterns of individual variation in definitions and goals. In any collective large enough to be called a society, there will be variation in the common culture, hence the character, of the important subgroups.[12]

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[9]James Q. Wilson, "The Urban Unease: Community vs. City," in Schmandt and Bloomberg (eds.), The Quality of Urban Life, op. cit., p. 458.

[10]Eliot Freidson, Patients' Views of Medical Practice (New York: Russell Sage, 1961), p. 196.

[11]Ibid., p. 201.

[12]Scott Greer, "Urbanization and Social Character," in Schmandt and Bloomberg (eds.), The Quality of Urban Life, op. cit., p. 100.

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Therefore, although neighborhoods in the same geographic location are subcultures within a larger common culture of society and share the same basic values and goals, nevertheless, as subcultures they may vary in the way they "perceive a set of circumstances as constituting illness or health, abnormality or normalcy, as calling for action or for disregarding."[13]

It is within this theoretical framework that an explanation might be sought for the study findings that differences among neighborhoods exist with respect to their residents' utilization of health services and their perceptions of available health care services. Also within this framework lies a potential explanation of why within the neighborhoods there was considerable variation in the degree and direction of the association between the variables of utilization and views of health care and the socioeconomic and demographic variables. Neighborhoods differ in the extent to which they meet the criteria of a community as discussed above. As Schmandt and Goldbach indicate:

> The notion of neighborhoods of urbanites vigorously place-oriented and rigidly dedicated to the maintenance of the status quo is subject to qualification. There are many such sub-areas where defense of hearth and home is intensely pursued. But there are also others with residents little committed to place, their major interests oriented outward.

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[13]Stanley H. King, Perceptions of Illness in Medical Practice (New York: Russell Sage, 1962), p. 67.

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> Between these two extremes, the intensity ranges widely.[14]

This statement by Schmandt and Goldbach is reflective of the fact that there are in reality two theoretical models of societal structure which may be employed in the study of community. The social system model is the one that appears to be most often used and was discussed at some length above. This is the model which emphasizes the unity, stability, interdependence, and commonality of goals and values in the community system. However, in the second theoretical model, the pluralistic model, the social order is not so much a product of unity and values held in common as it is a product of the interaction among a variety of diverse groups having their own interests to which they give priority. Often these groups may be in conflict with one another. However, some goals are shared in common.[15] Thus, in the pluralistic model emphasis is placed on the diversity within the community. Neither of these theoretical models alone is adequate to the task of providing a framework within which to conduct comparative studies of communities. For this purpose elements of both would have to be brought to bear on an understanding of relative behavioral and perceptive variations among residents from different communities.

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[14]Austin, op. cit., p. 78.

[15]Schmandt and Goldbach, op. cit., p. 478.

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Some neighborhood communities might in fact function as social systems of integrally interrelated and interdependent subgroups in which values and goals are commonly shared and where such commonly held values and goals supersede those of the individual subgroups within it. Other neighborhood communities more closely resemble the pluralistic model where, although some goals and values are shared in common, those of the individual subgroups are given priority and where such subgroups are often in conflict with one another. In the latter type community, since people tend to shy away from diversity and are unable to empathize with those whose values are different from their own, they attempt to avoid possible conflict by isolating themselves from the undesirable encroachment on their values.[16] Such isolation may take the form of individuals moving out of the particular neighborhood to put enough physical space between themselves, and those neighbors who have differing values, but just as often it takes on a more invisible form by establishing an emotional barrier which effectively minimizes the threat inherent in close interaction. Thus, close interaction is avoided and behavior and perceptions are not so much influenced by the immediate locality in which they live but by some outer-system with which identification is strong and whose values are shared.

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[16]Schmandt and Goldbach, op. cit., p. 479.

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Therein lies the potential explanation for the observed behavioral and opinion differences with respect to health care among residents in the three neighborhoods included in this study. Neighborhoods, as separate and distinct subcultural entities, differ from one another in terms of whether they function in accordance with the social systems model or the pluralistic model. This will be a determinant in whether the behavior and perception of residents are more influenced by a community ethos of shared values and norms, or by various sources outside the community with which subgroups within the neighborhood are more closely identified. To the extent the neighborhood operates as a social system wherein people identify closely with their neighborhood and interact intimately with one another (thereby maximizing the possibility of exerting a community influence on behavior and perceptions), those who reside within it will perceive social situations in similar ways and will act similarly to one another in response to these social situations. Thus, although variations among them in this regard may occur based on their differing socioeconomic and demographic characteristics, such differences will be minimal. On the other hand, if a neighborhood more closely resembles the pluralistic model, where interaction is minimal and the different groups within it operate in relative isolation from one another, the influence on the behavior and perceptions of the various groups within it is

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more likely to be exerted from groups outside the neighborhood with which identification and interaction are strong. Consequently, the behavioral and perceptive variations among the subgroups in this type community are likely to be substantial.

Within the context of the above it is possible to tentatively sketch the neighborhoods included in this study along a continuum ranging from that most closely resembling the social systems model to that which most closely resembles the pluralistic model. However, before attempting to tie these models into the particular study neighborhoods, a few general observations are in order.

Schmandt and Goldbach have suggested:

> Neighborhoods in which the concern of the residents revolves around the preservation of life-style values are likely to be more highly cognizant of space-related functions. . . .
>
> . . . [Neighborhoods in which residents' concerns are] undefined by space are less likely to evince a high degree of concern over place-related functions. . . .
>
> Lower middle class people who have equity in their own homes, often representing life savings, fewer mobility opportunities, insecurity, and fewer ties to the world outside the neighborhood are more bound to their neighborhood and, hence, have a high degree of spatially related interests.
>
> . . . A neighborhood dominated by apartment dwellers in the professional and managerial classes is less likely to manifest frantic concern with spatially related activities . . . [which] are not perceived as vital to the maintenance of their style of life. . . . Their investment in the neighborhood is negligible, their interest in it as a potential community minimal.

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> . . . The neighborhoods of the poor and the ghetto dwellers present still another case. . . . How much do ghetto residents want to preserve the life style of their neighborhoods, a style developed largely as a defensive mechanism against the hostility and unresponsiveness of the majoritarian society.[17]

In connection with the last observation, Cunningham noted:

> Racial apartheid is the strongest force acting against a sense of community. It is a divisive force based on emotion and therefore powerful and difficult to counter.[18]

Even so, Wilson suggests that:

> Perhaps a strong and stable family structure permits even persons of limited incomes to maintain a sense of community.[19]

Among the neighborhoods included in this study, the Hill District, South Oakland, and Hazelwood, Hazelwood it would seem is the one which most closely resembles the social systems model of community. It would appear that Hazelwood meets most of the criteria which were deemed important to the enhancement of a sense of community. It is essentially lower middle class with a high degree of home ownership tying people to their neighborhood. Few live in apartment buildings. Many of its residents are employed in their neighborhood, a preponderance of them in Jones and Laughlin, a steel mill situated in the neighborhood. It is an integrated neighborhood and although at times racial

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[17] Schmandt and Goldbach, op. cit., pp. 480-482.

[18] Cunningham, op. cit., p. 209.

[19] Wilson, op. cit., p. 469.

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tension has been high, there is close interaction between blacks and whites. Even among the various groups which often come into conflict with one another, the impression is that such conflict derives out of strong neighborhood sentiment, i.e., disagreements as to what is best for the community. Pride in the neighborhood and in the achievement of many of its residents with respect to the acquisition of material goods has resulted in many contesting its designation as a poverty neighborhood and resenting the intrusion of outside influences such as OEO. A predominantly Catholic neighborhood, many activities are centerd in the local church, and it might be assumed that maintaining a strong family life is emphasized.

To summarize in the words of Cunningham:

> To feel the warmth and intensity of identity in a district neighborhood, travel to Pittsburgh's Hazelwood-Glenwood. Talk to any of the citizens and you will hear them speak affectionately and unselfconsciously of their neighborhood as "the town." You will find most shop on the same two blocks . . . , more than half belong to the same parish church, and hundreds work in a neighborhood organization. . . .[20]

At the other end of the community spectrum, insofar as the study neighborhoods are concerned, is the Hill District. It is a ghetto neighborhood in which there are large public housing areas and a high proportion of apartment dwellers living in substandard housing. Many people who live in the Hill are reluctant to so admit. In our

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[20]Cunningham, op. cit., p. 209.

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survey sample, for example, many who lived in that part of the Hill which is close to South Oakland considered themselves as living in the latter neighborhood rather than in the Hill. Following the assassination of Martin Luther King, Jr., riots broke out in the Hill during which much destruction took place in the neighborhood. It is a neighborhood where many people are forced to live although they have the resources to live elsewhere but are prevented from doing so by discriminatory housing practices. There are also islands of attractive private housing where home ownership is high and there is also a large relatively new high rent apartment building. It might be guessed that for the most part interaction among all these groups is minimal as is their identification with the larger neighborhood. Similarly, many in the Hill are isolated from interaction because of age or abject poverty. There is a proliferation of many groups in the neighborhood vying for power and recognition, ranging from those with a militant separatist outlook to those which are more moderate. Until fairly recently, at least, such groups were at odds with one another and perhaps they still are, although they have been able to join in coalition around some major issues notably the need for opening the construction unions to blacks. However, this is an issue which is not limited solely to this neighborhood.

With regard to family solidarity in the Hill District, it is known that the Hill contains a great many

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fatherless families.

Community Action Pittsburgh has indicated that the Hill makes up most of the Model Cities area, and has always been the "top priority neighborhood for the Poverty Program."[21] Of the Model Cities area the funding proposal stated:

> . . . [it is] close to the inner city, where severe poverty exists--high unemployment--low-income families--substandard housing--inadequate educational opportunities--crime, disease, decay and hopelessness. . . . A major portion is a ghetto, predominantly negro--isolated--out of sight--out of mind--just existing. . . . It's an abrasive and destructive dead end.[22]

Between the two extremes on the community continuum lies South Oakland. It contains private residential areas where home ownership is high. But a large proportion of its residents are professionals and students who live in the many apartment buildings and converted homes. It is a highly transient neighborhood with large segments not particularly concerned with neighborhood activities, their orientation being primarily the advancement of self-interest. Blacks who live in South Oakland are few but they live in an essentially ghettoized area in only one census tract. Interaction among the residents in South Oakland is probably

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[21] Community Action Pittsburgh, Target Neighborhood Report: Social and Economic Conditions and Programs (Pittsburgh: CAP, 1969), p. II-6. (Mimeographed.)

[22] Links to Better Urban Living (application to the Department of Housing and Urban Development for a grant to plan a comprehensive city demonstration program; City of Pittsburgh, Pennsylvania, April 24, 1967), Part I, p. 5.

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high within the stable population, a large percentage of whom are Catholics, but probably is minimal between the large groups of students and other transients and the regular neighborhood residents. However, one might imagine a certain sense of neighborhood pride and identification insofar as South Oakland does contain prestigious universities, the Health Center of the University of Pittsburgh, and many institutions of cultural and historical significance. Also, there are many attractive and well-kept residential streets.

For the most part, the preceding discussion concerning the neighborhoods' ranking along a community continuum was impressionistic, unsubstantiated by empirical data systematically collected. Verification of these impressions and testing of the theoretical framework are beyond the scope of this study to provide and are suggested as possible areas for further research.

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CHAPTER VI

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Study Setting

This study was a secondary analysis of data on consumer utilization of health care and consumer views of available health care in three contiguous poverty neighborhoods in Pittsburgh: the Hill District, South Oakland, and Hazelwood. These neighborhoods, located in the primary service area of Presbyterian-University Hospital are the major target areas of its Health Care Expediter Project. These data were part of a larger body of data collected in connection with program activities of the Health Care Expediter Project, the main objective of which is to represent the health interests of residents in these neighborhoods to the hospital administration. As one approach to carrying out this primary aim a survey in the neighborhoods was launched in the Fall of 1969 to explore the views of residents relative to health and the health care available to them, to become aware of the extent of their utilization of available health services, and to gain a subjective assessment of their health.

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Relevant Literature

The literature, both popular and professional, as reviewed herein, was replete with evidence of the excessive burden of illness borne by the poor in contrast to the more advantaged classes. It followed, therefore, that the poor were in need of more health services than other classes. Yet the overwhelming weight of evidence indicated that they actually utilized either fewer than, or the same amount of, health services as their better-off neighbors. These conclusions were drawn consistently throughout the literature regardless of which measures were used to determine consumption of health care and irrespective of the locus of the studies. Further, it was clear that by all measures and holding socioeconomic and demographic variables constant, nonwhites, specifically blacks, came off worse than their white counterparts in all categories.

Study Problem

However, in spite of the accumulated knowledge of experts relative to the relationship of poverty, ill health, and low consumership of health care which interact to create a cycle of poverty and ill health, the literature indicated that surprisingly little is known concerning in what light the poor themselves view available health care. At a time when organizers, planners, and citizen activists are clamoring for more consumer participation and representation in

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those decisions which affect their lives, the position of this study was that it is essential that the views of consumers and potential consumers of health care be explored. Although some initial efforts in that regard had been undertaken nationally, it was felt much more needed to be done especially at the community or neighborhood level. Studies revealed reason to believe that the poor do not always share the pessimistic views of experts regarding the adequacy of services in general, viewing them more favorably than the weight of expert opinion would warrant. The possibility that the same held true in the area of health services was considered important to explore.

In addition, it was felt that perhaps national figures or those compiled in particular localities were not necessarily specifically applicable to communities in different geographic locales even if seemingly they bore similar socioeconomic and demographic characteristics. As with people, individual communities differ considerably from one another, and in the aggregation of data leading to generalizable findings, it was felt much of this individual character might be obscured.

Study Objectives

Three major study objectives were set forth for the analysis of the data on utilization of health care and views toward available health care. These were:

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1. To describe (a) how residents in three local contiguous poverty neighborhoods view health care available to them, and (b) how their families utilize health care services. We were also interested in seeing how these two variables were related to race, age, education, and income in this population.

2. To find out whether or not important information about each neighborhood in connection with these variables was lost in the aggregation of data for all three.

3. To learn whether or not the neighborhood in which one resides influences his attitudes and utilization independent of socioeconomic and demographic factors and independent of the unevenness of the availability of health care from one neighborhood to another.

The utilization and opinion variables as well as the socioeconomic, demographic, and neighborhood variables were operationally defined in terms of specific indicators (subvariables) employed for their analysis, and the rationale for selection of the specific indicators was discussed as they appeared in the analysis. Several assumptions were made.

Assumptions

1. Aggregated data for the three study neighborhoods would replicate findings of other studies in terms of the relationship between socioeconomic and demographic variables of age, income, education, and race and variables

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of utilization.

2. Residents' views of available health care would be positive in all socioeconomic and demographic groupings.

3. There would be differences among residents from community to community in their utilization of health services and in their views of available health care.

4. Differences among residents in their utilization of health services and in their views of available health care would remain even when holding socioeconomic and demographic factors constant and would not be explained by variations in availability of health care services among the neighborhoods.

The Sample

Using a table of random numbers, one hundred dwelling units in each of the three neighborhoods were selected for inclusion in the study. Further, within each dwelling unit only one household was included.

The Instrument

The instrument employed for data collection was a structured interview questionnaire with some open-ended subparts to permit elaboration on answers to certain questions. The instrument was divided into four basic sections. The first section asked questions related to utilization of health care services; the second was addressed to collecting information related to the health of the respondent and

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family; the third contained items concerning opinions and attitudes of the respondents toward available health care; and the fourth dealt with socioeconomic and demographic data.

The Health Care Expediters conducted all data collection interviews. Data collection began in October, 1969, and continued through January, 1970. Whenever possible the person interviewed was the female head of the household.

A household unit was defined as consisting of either an unattached individual living alone or with nonrelated people, a married couple, or a parent or parents and their children. In the event of two or more family units living in the same apartment, the person interviewed was the female head of the family unit whose member answered the door.

Response rates were 95 percent for the Hill District, 90 percent for South Oakland, and 75 percent for Hazelwood. The response rate for the sample as a whole was 86.7 percent.

Findings

Utilization of Health Care Services

The level of utilization of the study population was very high on all commonly employed indicators with an overwhelming majority of families having utilized health care services within the year preceding the study period. Virtually all families relied heavily on professionals as their primary source of health information. This was true

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both for blacks and whites and for all age, education, and income groups.

Four indicators of utilization were selected for more detailed analysis in connection with exploring the relationship between neighborhood of residence and utilization. It was found that on three of the four indicators of utilization employed there was an association between where the respondents lived and their families' utilization of health care. The differences in utilization among the individual neighborhoods was substantial and tended in the direction of higher utilization among families in the neighborhood with the lowest priority for anti-poverty efforts and lowest in the top priority neighborhood.

It was also found that important utilization information on the three neighborhoods individually was lost in the aggregation of data for the three when considering the study population as a whole. This was reflected in the fact that not only were there substantial differences in utilization from one neighborhood to another, but there were also such differences between two neighborhoods and the aggregated total on three out of the four indicators.

An attempt was made to explain the observed association between neighborhood and utilization by introducing as test factors four socioeconomic and demographic variables: race, age, education, and income. None of these test factor variables was able to explain the observed association

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between neighborhood and utilization. Thus, the neighborhood in which one lived was found to be a cogent independent factor in utilization of health care.

The variable of availability, in its geographic and economic connotations, was discussed as a possible factor, accounting for observed differences in utilization among the neighborhoods. Limited data did not permit a systematic and extensive analysis of this important variable in its relationship to utilization. However, there was evidence in the data to suggest that in the study neighborhoods neither geographic nor economic accessibility could entirely account for differential utilization among the neighborhoods.

Views of Available Health Care Services

The findings revealed that a substantial majority in the total study population held favorable views of available health care as reflected by their responses on all six opinion items employed. However, there were significant differences between the percentages of respondents in the different neighborhoods holding such opinions (substantial differences occurring in five out of the six indicators). Nonetheless, the overwhelming majority felt that the poor are not constrained in their choice of treatment source and that the treatment the poor receive is equal to that of other groups.

The neighborhood in which respondents lived was found to be an important factor influencing the views of

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those residing within it as reflected by substantial response differences among residents in the different neighborhoods. Although the total population when stratified for socioeconomic and demographic variables revealed differences among the contingent race, age, education, and income categories, differences appeared to be as much a function of the particular neighborhood of residence as it was of race, age, education, or income. Evidence to support that contention was found when opinions of the respondents were analyzed by race, age, education, and income, separately, controlling for neighborhood of residence in each case.

With race the variable, the study population as stratified by neighborhood showed significant differences between blacks and whites on two of the six indicators. In the individual neighborhoods, blacks and whites on the Hill differed on four out of six; in South Oakland on two out of six; and in Hazelwood on one out of six. Interestingly, blacks compared from neighborhood to neighborhood differed on all six indicators and whites on five out of the six.

With age the variable, the study population as stratified by neighborhood showed significant differences between the age groups on five out of the six indicators. Going to the neighborhoods, the Hill showed differences on five out of the six indicators, South Oakland on two out of the six, and Hazelwood on two out of the six. Comparing like cohorts from neighborhood to neighborhood, the under

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40 group differed on four out of the six indicators, the 40-60 group on five, and the over 60 group on five.

With education the variable, the total population differed on two out of the six indicators. The Hill differed on all six, South Oakland on two, and Hazelwood on only one. Comparing like educational cohorts from neighborhood to neighborhood, those with under 9 years of schooling differed on four out of six indicators, those with 9-12 years on all six, and those with over 12 years (excluding Hazelwood) on four.

For the last variable used, income, the study population as stratified by neighborhood differed on two out of the six indicators. On the Hill the three income groups differed on four out of the six indicators, in South Oakland on two, and in Hazelwood on three. Comparing like income categories from neighborhood to neighborhood showed that those respondents with an income under $4,000 differed on all six indicators, those earning between $4,000 and $8,000 on four, and those earning over $8,000 on four.

Thus it became clear that among the three neighborhoods the relationship between the socioeconomic and demographic variables within each one showed little consistency. Further, there were large response differentials among those in the same socioeconomic and demographic contingent groups from one neighborhood to another. This strongly supported the thesis that regardless of the race,

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age, education, or income of the respondents, their views of available health care were influenced in large measure by the neighborhood in which they lived.

Implications for Theory

Evidence was found in the study data that neighborhood of residence was an important independent factor in the respondents' utilization and views of available health care. This suggested that something within the ethos of a neighborhood acts to influence the behavior of those who reside within it. It was not within the limited scope of the data to suggest what in the ethos of the neighborhood might be such a strong influencing factor; an explanation was therefore sought in those theoretical concepts which have some relevance to neighborhood. Some of these theoretical concepts were woven together to provide a theoretical framework within which an explanation of the variation among residents in different neighborhoods might be sought in the context of the differing neighborhood ethos.

Two theoretical models of community were discussed: (1) the social systems model, and (2) the pluralistic model. The social systems model emphasizes unity, stability, interdependence, and commonality of goals and values in the community system. In the pluralistic model, the social order is not so much a product of unity and values held in common as it is a product of the interaction among a variety

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of diverse groups each having its own interests to which it gives priority. The emphasis in this model is thus on diversity within the community.

It was suggested that neighborhood communities range along a continuum from those which resemble the social systems model to those which resemble the pluralistic model. The study neighborhoods were tentatively sketched along such a continuum, with Hazelwood most closely resembling the social systems model of community, the Hill District the pluralistic model, and South Oakland falling between the two extremes. Within this context the following explanation of the study findings was posited.

As separate subcultural entities neighborhoods differ from one another in terms of whether they function in accordance with the social systems model or the pluralistic model of community. This will be a determinant in whether behavior and perception among neighborhood residents are more influenced by a community ethos of shared values and norms or by various sources outside the community with which subgroups within the neighborhood are more closely identified. To this extent a neighborhood operates as a social system thereby maximizing the opportunity to exert a community influence on behavior and perceptions, those who reside within it will perceive social situations in the same way and will behave similarly in response to these social situations. Variations among neighborhood residents might

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be observed due to their differing socioeconomic and demographic characteristics, but such variation will be minimal. However, if the neighborhood more closely resembles the pluralistic model, where interaction is minimal and the different groups within the neighborhood operate in relative isolation from one another, influence on behavior and perceptions will more likely be exerted from groups outside the neighborhood with which identification and interaction are strong. Thus, behavioral and perceptive variations among subgroups in this type of neighborhood are likely to be substantial.

It was recognized that this theoretical discussion was highly speculative in the sense that it was impressionistic and unsubstantiated by empirical data. Similarly, it was recognized the theoretical framework itself needed to be tested. Both the verification of the impressions about the neighborhood and the testing of the theoretical framework were beyond the scope of this study and remain as tasks for further research.

Implications for Planning

The study findings suggest two major implications for planning and implementing health programs in areas where experts feel there is a need:

1. Any planning or programming in connection with utilization of services must reckon seriously with the

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uniqueness of each of the particular communities to be thus served even on a neighborhood level. It should not be assumed that although neighborhoods are in the same geographic location and have many important characteristics in common, they can be lumped together for massive efforts as if they were all one and the same unit. This suggests the need for establishing at least baseline data on each community to be served. The importance of this is supported by the weight of the study results showing that among residents in our three geographically contiguous poverty-designated neighborhoods there were important utilization differences from one neighborhood to another.

2. Any effort to plan and/or implement health care programs must be preceded by a massive educational campaign to make the people at the grass roots cognizant of the needs. This is a first step in attempting to involve them in the planning process. Any problem-solving effort can succeed only to the extent those who are to be helped are aware that a problem exists. They then can be brought into meaningful involvement in planning solutions. Such a strategy is suggested by the fact that despite the weight of expert opinion with respect to the miserable status of health (and other social) programs and conditions in the study neighborhoods, the preponderant majority of respondents in these neighborhoods were satisfied with the resources that were available to them. Whether such satisfaction

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derives out of the consumers' ignorance of their needs or their apathy due to past frustrations, to be successfully implemented and subsequently utilized, plans and programs will require the active participation of a motivated and well-informed constituency.

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APPENDICES

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APPENDIX A

INTERVIEW QUESTIONNAIRE

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Hello! My name is _____. I would like to speak with the woman in charge of the household. I am a Health Care Expediter hired by Presbyterian-University Hospital to represent the health interest of our community to the Hospital and to Falk Clinic. In order to help plan better medical services for our community and in order for us to do our job better, we want to find out what the people see as their health care needs, how they are being met, what they think about the medical care they receive, and what suggestions they may have for changes and improvements in service. All the information which you give will be strictly confidential and under no circumstances will your name be revealed.

I thought we might start off with a few questions about your family doctor, dentist, and other medical facilities you might use.

1. Do you and your family have a personal family physician?

_____ No response (skip to question 2)
_____ No (skip to question 2)
_____ Yes

If Yes:

A. Where is his office?

_____ No response (go on to part B)
_____ Don't know (go on to part B)
_____ In own neighborhood
Specify_____
_____ In another part of the city
Where _____

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B. Do any members of your family see any other doctor?

_____ No response (go on to question 2)
_____ Don't know (go on to question 2)
_____ No (go on to question 2)
_____ Yes

What type of doctor do they see?

_____

2. Do you and your family have a regular family dentist?

_____ No response (go on to question 3)
_____ Don't know or undecided (go on to question 3)
_____ No (go on to question 3)
_____ Yes

Where is his office?

_____ No response
_____ Don't know
_____ In own neighborhood
Specify_____
_____ In another part of the city
Where _____

3. Do you ever use a clinic for medical or dental care?

_____ No response (skip to question 4)
_____ Don't know (skip to question 4)
_____ No (skip to question 4)
_____ Yes

If Yes:

A. What clinics have you and your family used for medical and/or dental care? (Probe for all clinics used.)

_____ _____
_____ _____

B. Where are these clinics located?

_____ No response
_____ Don't know
_____ In own neighborhood
Specify_____

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_____ In another part of the city
Where _____

4. Has anyone been visited by a Public Health or Visiting Nurse or anyone else who helped with health problems during the past year?

_____ No response (go on to question 5)
_____ Don't know (go on to question 5)
_____ No (go on to question 5)
_____ Yes
Which ones_____

5. During the past year, have you or anyone in your family gone to any hospital, clinic, health center, or doctor for any kind of treatment?

_____ No response (skip to question 6)
_____ Don't know (skip to question 6)
_____ No (skip to question 6)
_____ Yes

If Yes:

A. Which did you/they go to?

_____ No response
_____ Hospital
_____ Clinic
_____ Health Center
_____ Doctor

B. How many times did you/they go to (Place)
(ASK FOR EACH PLACE MENTIONED)

Record number _____

6. When was the last time you or anyone in your family went to a clinic or saw a doctor at any time?

Record date _____

7. On this last visit did you/he/she have an appointment; was it an emergency; or did you/she/he just stop by?

_____ No response
_____ Don't know
_____ Emergency
_____ Stopped by
_____ Appointment

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8. How long does it usually take you to get to the doctor's office/clinic?

_____ No response
_____ Don't know
_____ Less than 1/2 hour
_____ 1/2 hour or more but less than one hour
_____ One hour or more

9. When you get to the doctor's office/clinic, how long do you usually have to wait before seeing a doctor?

_____ No response (skip to question 10)
_____ Don't know (skip to question 10)
_____ Do not have to wait (skip to question 10)
_____ Less than 1/2 hour
_____ 1/2 hour or more but less than one hour
_____ One hour or more

Do you mind waiting?

_____ No
_____ Yes

If Yes, ask how much:

_____ A great deal
_____ A little

10. Do you know of any doctors, clinics, health centers, or hospitals, in this area, that give free or low cost medical care to needy persons, even if they are not covered by insurance, medical assistance, or anything else?

_____ No response (go on to question 11)
_____ Don't know or no (go on to question 11)
_____ Yes

What doctors or places are these?

_____
_____
_____

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11. Have you and your family used Falk Clinic in the past twelve months?
(DO NOT ASK IF FALK CLINIC WAS MENTIONED PREVIOUSLY AS A SOURCE OF MEDICAL CARE; JUST CHECK THE ANSWER IN THE PROPER SPACES.)

_____ No response (go on to part C)
_____ Don't know (go on to part C)
_____ No (go on to part C)
_____ Yes

If Yes:
How do you feel about Falk Clinic? (PROBE)

_____
_____

If No:
Have you heard about Falk Clinic?
_____ No
_____ Yes
Why haven't you used it?_____
_____

(NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE HEALTH OF YOUR FAMILY AND WHAT YOU FEEL ARE YOUR HEALTH CARE NEEDS.)

12. Does anyone in the family have some long-term health problem or handicap that keeps him/her from working, going to school, or limits the kind or amount of activity he/she can engage in?

_____ No response (go on to question 13)
_____ Don't know (go on to question 13)
_____ No (go on to question 13)
_____ Yes
Would you please tell me who that is and what is wrong?

Who?	_____ Self	_____ Husband	_____Children
What is wrong?	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

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13. If you had a chance to talk with a doctor at no cost to you, are there any things about your family's health you would like to ask him about?

_____ No response (go on to question 14)

_____ Don't know (go on to question 14)

_____ No (go on to question 14)

_____ Yes
What would that be_____
_____

14. In the past year have you or any member of your family had any of the following health problems?
(CHECK ALL ANSWERS TO WHICH A "YES" RESPONSE IS GIVEN.)

	Self	Husband	Children
_____ High blood pressure	_____	_____	_____
_____ Heart	_____	_____	_____
_____ Stroke	_____	_____	_____
_____ Lung trouble (bronchitis, emphysema, TB, etc.)	_____	_____	_____
_____ Deformities or crippling problems (arthritis, rheumatism, etc.)	_____	_____	_____
_____ Cancer	_____	_____	_____
_____ Venereal disease	_____	_____	_____

_____ Other problems:
Specify what and who_____
_____

15. Does anyone in the family have any dental problems you haven't been able to take care of yet?

_____ No response (go on to question 16)

_____ Don't know (go on to question 16)

_____ No (go on to question 16)

_____ Yes
Who would that be? ___Self ___Husband___Children
Why is that?_____
_____
_____

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16. During the past year, did anyone have to have an eye or ear examination?

_____ No response (go on to question 17)
_____ Don't know (go on to question 17)
_____ No (go on to question 17)
_____ Yes
Who was that? ___Self ___Husband ___Children
What was the trouble?_____
_____

17. During the past year, did anyone have to buy eyeglasses or a hearing aid?

_____ No response (go on to question 18)
_____ Don't know (go on to question 18)
_____ No (go on to question 18)
_____ Yes
Who was that? ___Self ___Husband ___Children
Where did you get them?_____
Who paid for them?_____

18. When you or someone in the family are not feeling well, do you usually put other things aside and try to see a doctor right away, or do you wait to see if it clears up by itself?

_____ No response (go on to question 19)
_____ Don't know (go on to question 19)
_____ Right away
_____ Wait to see

19. Is anyone in the family putting off any medical or other health care that you think he/she should get, but has not gotten for one reason or another?

_____ No response (go on to question 20)
_____ Don't know (go on to question 20)
_____ No (go on to question 20)
_____ Yes
Who would that be? ___Self ___Husband ___Children
Why is that?_____
_____

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20. Has anyone from any agency advised you that someone needed medical care, or helped you find out where and how to get it?

_____ No response (go on to question 21)

_____ Don't know (go on to question 21)

_____ No (go on to question 21)

_____ Yes

Who needed the care? ___Self ___Husband ___Children

What agency was that?_____

_____

21. In general, where do you get helpful advice about health problems?

_____

22. (HAND RESPONDENT CARD)
On the card I just gave you are listed other possible sources of information. Please look over the list and tell me which sources you have found to be helpful.

_____Relatives. Supply which one if possible. _____

_____Neighbors and other friends. _____

_____Local newspapers _____

_____Magazine articles _____

_____Radio _____

_____Family doctor _____

_____Public health workers such as physician, nurse, etc. _____

_____Druggist _____

_____School doctor, nurse, dental hygienist or teacher _____

_____Books, bulletins or pamphlets _____

_____Dentist _____

_____Local meetings (SPECIFY)_____ _____

_____TV _____

_____Extension Service (Home demonstration,etc.) _____

_____Other (SPECIFY)_____ _____

Of all the ways we have just mentioned, which one do you depend on most? Indicate by placing a 1 to right of item in question 22.

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Which is the second most important? Indicate by placing a 2 to right of item in question 22.

Which is the third most important? Indicate by placing a 3 to right of item in question 22.

23. Does anyone in the family have any kind of health insurance that you pay into--like Blue Cross or a health benefit plan from work--that pays all or a part of medical bills?

_____ No response (skip to question 24)

_____ Don't know (skip to question 24)

_____ No (skip to question 24)

_____ Yes

If Yes:

What does the policy pay for?

_____ Hospital room and board

_____ Bills for operations

_____ Ordinary doctor bills

_____ Other medical expenses

Is anyone not covered by this insurance?

_____ No response (skip to question 24)

_____ Don't know (skip to question 24)

_____ No (skip to question 24)

_____ Yes

Who is not covered?_____

24. Have you or anyone in your family established eligibility for payment of medical care under one or another of the public programs such as public assistance, medicaid, or medicare?

_____ No response (skip to question 25)

_____ Don't know (skip to question 25)

_____ No (skip to question 25)[P]

_____ Yes

Which programs and who is eligible?	___Self	___Husband	___Children
_____ No response	____	____	____
_____ Don't know	____	____	____
_____ Public Assistance	____	____	____

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	Self	Husband	Children
_____ Medicaid	____	____	____
_____ Medicare	____	____	____

(NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS THAT DEAL WITH HOW YOU FEEL ABOUT THE MEDICAL CARE YOU RECEIVE OR IS AVAILABLE TO YOU AND WHAT SUGGESTIONS OR COMMENTS YOU MIGHT HAVE ABOUT IT.)

25. Have you or your family changed physicians or clinics in the past year?

_____ No response (skip to question 26)

_____ Don't know (skip to question 26)

_____ No (skip to question 26)

_____ Yes

If Yes: (AFTER COMPLETING SECTIONS A & B, GO ON TO QUESTION 27)

A. Why did you change?_____

_____

B. Do you like the new doctor/clinic better?

_____ No response (skip to question 27)

_____ Don't know (skip to question 27)

_____ No (skip to question 27)

_____ Yes

What do you like about the new doctor/clinic?

_____

_____

26. Have ycu ever thought of changing to another doctor or clinic?

_____ No response (skip to question 27)

_____ Don't know (skip to question 27)

_____ No (skip to question 27)

_____ Yes

Why haven't you changed?_____

_____

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27. Suppose you or someone in the family were sick enough to need medical care. If it cost the same and were just as close, would you rather go to a clinic, a private doctor, an emergency room, or somewhere else?

_____ Nc response (skip to question 28)

_____ Don't know or no preference (skip to question 28)

_____ Clinic

_____ Private doctor

_____ Emergency room

_____ Other; where?_____

Why is that?_____

28. Are there any things about clinics which you particularly like?

_____ No response (go on to question 29)

_____ Don't know (go on to question 29)

_____ No (go on to question 29)

_____ Yes
What are they?_____

29. Are there any things about clinics which you particularly dislike?

_____ No response (go on to question 30)

_____ Don't know (go on to question 30)

_____ No (go on to question 30)

_____ Yes
What are they?_____

30. Are there any things which prevent you or other members of your family from using clinics more than you do now such as baby sitting problems, transportation problems, clinic hours, waiting in clinics or any other problem?

_____ No response (skip to question 31)

_____ Don't know (skip to question 31)

_____ No (skip to question 31)

_____ Yes
What are they? (CHECK ALL MENTIONED)

_____ Baby sitting problems

_____ Transportation

_____ Clinic hours

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_____ Waiting
_____ Personnel at the clinic
_____ Expense
_____ Impersonality
_____ Other (SPECIFY) _____

31. Do you think that people who are eligible to get free medical care through their local welfare departments must go to a certain place, or can they go anywhere for care?

_____ No response (skip to question 32)
_____ Don't know (skip to question 32)
_____ Certain places
_____ Anywhere

32. In your opinion, do you think that doctors or clinics give the same service to people on welfare, as they do to most other patients?

_____ No response (go on to question 33)
_____ Don't know (go on to question 33)
_____ About the same
_____ Poorer ____doctor ____clinic ____both
_____ Better
In what way?_____

33. Do you know of anyone who has ever had trouble getting care from a doctor or clinic because of discrimination?

_____ No response (go on to question 34)
_____ Don't know (go on to question 34)
_____ No (go on to question 34)
_____ Yes

Was this by a doctor or clinic?

_____ Doctor
_____ Clinic
_____ Both

What was the trouble in getting care?_____

_____

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34. In general, do you feel that our community has adequate health services?

_____ No response (go on to question 35)

_____ Don't know (go on to question 35)

_____ Yes, adequate (go on to question 35)

_____ No, inadequate

If No:

What would you say are some of the health needs that are not being met?

_____

_____

What would you like to see added to better meet these needs?

_____

(FINALLY, I WOULD LIKE TO ASK A FEW QUESTIONS ABOUT YOUR FAMILY.)

35. Are you married, single, divorced, separated, or widowed?

_____ No response (skip to question 40)

_____ Single, never married (skip to question 40)

_____ Divorced (skip to question 39)

_____ Separated (skip to question 39)

_____ Widowed (skip to question 39)

_____ Married

36. What kind of work does your husband do for a living?

_____ No response (skip to question 38)

_____ Not employed (skip to question 38)

_____ Retired (ASK PREVIOUS OCCUPATION)_____ (skip to question 38)

_____ Employed (RECORD OCCUPATION) _____

37. Would your husband lose any pay if he were laid up for a day?

_____ No response _____ No

_____ Don't know _____ Yes

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38. What is your husband's age? _____

39. How far did he go in school? (RECORD NUMBER OF YEARS)
_____

40. If you work, what is your occupation? (RECORD OCCUPATION) _____

41. Does your family have any other source of income?
_____ No response
_____ Don't know
_____ No
_____ Yes (SPECIFY SOURCES) _____
(IF NO OCCUPATION OR IF HOUSEWIFE, SKIP TO QUESTION 43.)

42. Would you lose any pay if you were laid up for a day?
_____ No response
_____ Don't know
_____ No
_____ Yes

43. What is your age? _____

44. How far did you go in school? _____ years

45. How many children do you have? _____

46. What are their ages? _____

47. Are there any other adults who live with you?
_____ No response (go on to question 48)
_____ No (go on to question 48)
_____ Yes
Are they related or unrelated to you?
_____ Related
_____ Unrelated
What are their ages? _____

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48. What is your family's income per year?

_____ No response (go on to question 49)
_____ Below $2,000
_____ Above $2,000 but below $3,200
_____ Above $3,200 but below $4,000
_____ $4,000 - $5,999
_____ $6,000 - $7,999
_____ $8,000 - $9,999
_____ $10,000 or more

49. How long have you lived in (Hazelwood, the Hill, South Oakland)?

_____ No response (go on to question 50)
_____ Less than one year
_____ 1 - 3 years
_____ 3 - 10 years
_____ Over 10 years

50. Where did you live before?

_____ No response (go on to question 51)
_____ In another part of Pittsburgh (SPECIFY WHERE) _____
_____ Out of Pittsburgh but in the state (SPECIFY WHERE) _____
_____ Out of state (SPECIFY WHERE) _____

51. What is your religious preference?

_____ No response (go on to question 52)
_____ Protestant
_____ Catholic
_____ Jewish
_____ Other -- What? _____

Complete the following by observation:

52. A. Race

_____ White _____ Oriental
_____ Negro _____ Other

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B. Kind of place respondent lives in:

1. Single family dwelling

_____ Detached

_____ Row House

2. Flat:

_____ First floor

_____ Upstairs

3. Apartment building:

(RECORD APPROXIMATE NUMBER OF OTHER APARTMENTS IN BUILDING.)

_____

C. (PLEASE COMMENT ON:)

1. The course of the interview (was respondent cooperative, quality of the interview, is the information of value, etc.)

2. Conditions in the home (adequate space, furnishing, general physical conditions, etc.)

3. Were there any immediate health related problems that were uncovered during the interview for which some kind of direct service was offered? If there were, please specify the nature of the problem and the kind of help given (as briefly as possible).

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APPENDIX B

SELECTED HEALTH DATA

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TABLE 20

BIRTH*, DEATH*, AND CASE RATES** BY NEIGHBORHOOD (1967)

Rates	Hill	South Oakland	Hazelwood
Birth	15.8	13.8	10.5
Death	14.5	14.6	13.6
Syphillis	439.5	93.5	52.3
Gonorrhea	1213.8	415.4	156.9
Tuberculosis			
Active	123.0	41.5	26.1
Other	73.3	72.7	52.3
Known	1161.5	477.7	235.3
Rheumatic Fever	26.1	41.5	10.5

*Birth and death rates per 1,000 population.

**Case rates per 100,000 population.

SOURCE: Allegheny County Health Department, Project Proposal: Communicable Disease--Comprehensive Health Services (Pittsburgh, Pennsylvania: ACHD (February, 1969), p. 200.

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TABLE 21

FAMILIES IN WHICH SOMEONE HAD ACTIVITY LIMITING CONDITION BY NEIGHBORHOOD

Have Activity Limiting Condition	% Hill	% South Oakland	% Hazelwood
Yes	27.4	8.9	14.6
No	71.6	90.0	85.3
Don't Know	1.1	1.1	0.0
Total	100.0	100.0	100.0
	N=(95)	(90)	(75)

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TABLE 22

NUMBER OF ACTIVITY LIMITING CONDITIONS FOR FAMILIES WHICH HAD THEM BY NEIGHBORHOOD

Number of Conditions*	Hill %	South Oakland %	Hazelwood %
One Major Condition	57.7	75.0	81.8
Two Major Conditions	15.2	12.5	1.3
No Major--But Multi-Minor Conditions	3.8	0.0	0.0
Other	23.1	12.5	1.3
Total	100.0	100.0	100.0
	N=(26)	(8)	(11)

*Major conditions are: heart, arthritis and rheumatism, mental and nervous disorders, high blood pressure, visual impairment, orthopedic impairment, and cancer.

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TABLE 23

FAMILIES WHO HAVE SOMETHING TO ASK A DOCTOR ABOUT BY NEIGHBORHOOD

Something to Ask a Doctor	Hill %	South Oakland %	Hazelwood %
Yes	47.4	45.6	21.3
No	50.5	42.2	78.7
No Response & Don't Know	2.1	12.2	0.0
Total	100.0	100.0	100.0
	N=(95)	(90)	(75)

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TABLE 24

CONCERNS ABOUT WHICH RESPONDENTS WOULD LIKE TO SPEAK TO A DOCTOR BY NEIGHBORHOOD

Concerns	Hill %	South Oakland %	Hazelwood %
General Health	28.9	19.5	62.5
Specific Illness	26.7	46.3	6.2
A Family Member	33.3	17.1	31.3
Other	11.1	17.1	0.0
Total	100.0	100.0	100.0
	N=(45)	(41)	(16)

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TABLE 25

ADVISED BY AGENCY SOMEONE IN FAMILY NEEDED HEALTH CARE BY NEIGHBORHOOD

Advised Needed Health Care	Hill %	South Oakland %	Hazelwood %
Yes	22.1	2.2	6.6
No	74.7	96.7	90.7
No Response & Don't Know	3.2	1.1	2.7
Total	100.0	100.0	100.0
	N=(95)	(90)	(75)

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TABLE 26

WHEN A DOCTOR'S SERVICES WILL BE SOUGHT WHEN ILL BY NEIGHBORHOOD

Services Will Be Sought	Hill %	South Oakland %	Hazelwood %
Right Away	31.6	21.1	52.0
Wait to See	66.3	78.9	48.0
Don't Know	2.1	0.0	0.0
Total	100.0	100.0	100.0
	N=(95)	(90)	(75)

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APPENDIX C

MAP SHOWING LOCATION OF MAJOR HEALTH CARE RESOURCES IN THE STUDY NEIGHBORHOODS

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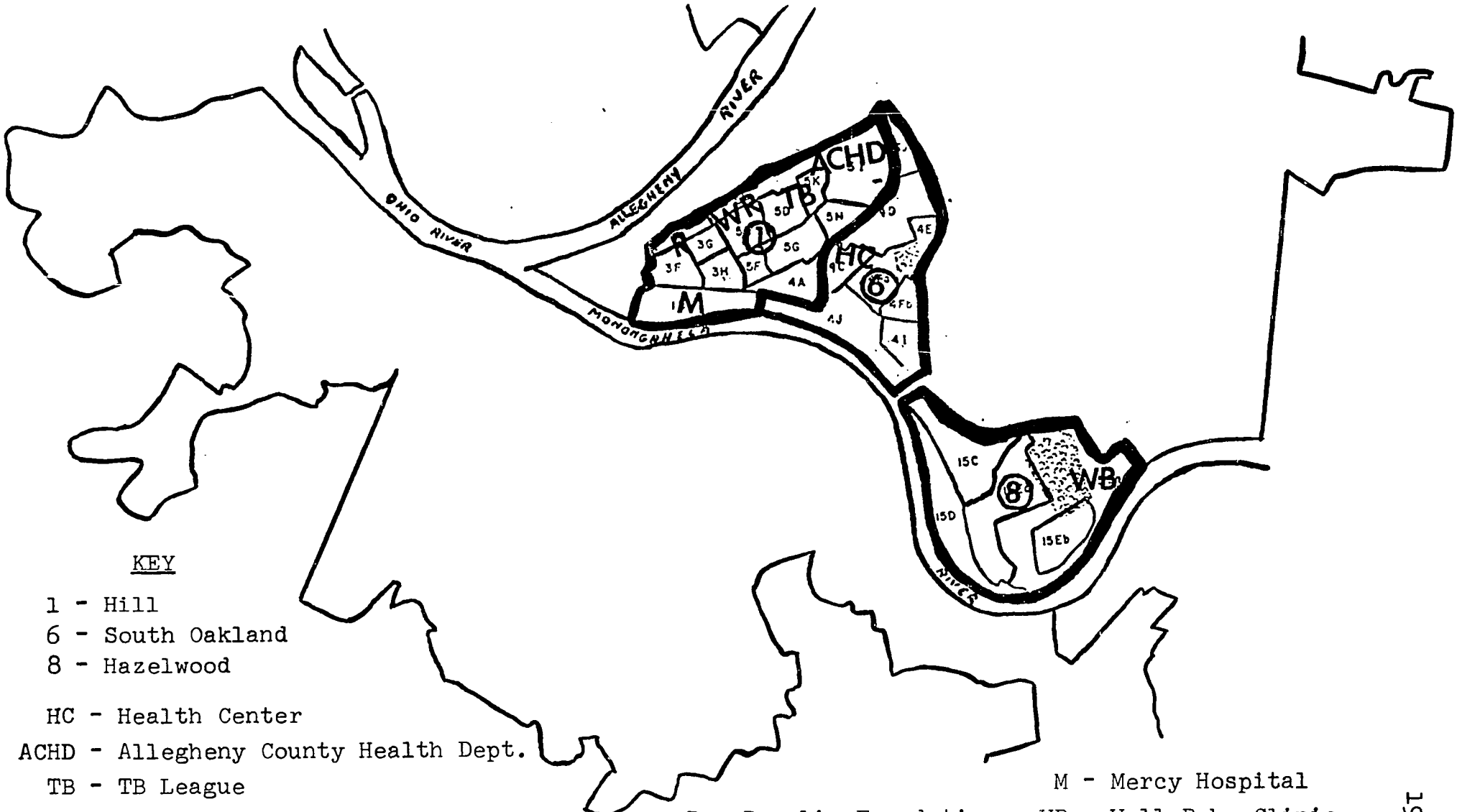

KEY

1 - Hill
6 - South Oakland
8 - Hazelwood

HC - Health Center
ACHD - Allegheny County Health Dept.
TB - TB League
WR - Western Restoration
R - Rosalia Foundation
M - Mercy Hospital
WB - Well-Baby Clinic