Outside Europe

An urban community health project*

E H PATERSON

Long ago in the dark ages, when I was still a medical student, sick people were called patients—that is, passive agents, and my revered seniors expected them to behave as such. They were to ask no questions, but were to be entirely passive agents on whom the gifted doctors could practise their noble art.

Today, though sick people are still called patients, things have changed a great deal. For nowadays patients want to ask questions, to understand something of their disease and its treatment, and to accept some degree of responsibility for the eventual outcome. Many patients benefit greatly from this more mature co-operative approach to medical care. There is a growing feeling that acceptance of a degree of personal responsibility is essential for individual health, for health care is not something that can be totally contracted out to hired experts, whether they be consultant surgeons in a hospital or professional masseurs in an executive gymnasium. Personal involvement in one's own care is itself a health-generating activity.

Health of communities

Traditionally a sick community has been treated as an old-style patient. Experts have made their diagnosis and prescribed their treatments—better water supplies, improved nutrition, immunisation programmes, and the like—and governments have administered them. But today in a few places in the Third World some communities have begun to feel that if they wait for their government to give them what they need, they may have to wait a very long time indeed. Even then the treatment may not be what the community really needs, only what some expert says it ought to need. So these few communities have begun to take their health care into their own hands, with the help of dedicated medical workers. They have made their own diagnosis, worked out their own plan of treatment, and carried it through at an appropriate technological level, a level which the community can afford to sustain indefinitely. This may mean draining a malarial swamp, or promoting family planning, or having one of their members trained as a health worker or barefoot doctor. But, because the people have done it themselves, it is likely to be apposite, cheap, and sustained. Through this action the community will grow in maturity and morale, for as in the case of the individual, involvement in community care is itself a health-generating activity. Such programmes have been labelled "community health programmes," health-orientated and community-based.

All such programmes that I know of have been rural. The problems that rural communities face and their solutions have been relatively simple, though this does not detract from their

*Based on a paper delivered at the BMA Congress, Hong Kong, November 1979.

achievements and significance. But this world is moving rapidly into an age of enormous cities, and I believe we must ask ourselves urgently if there are any corresponding solutions to the question of our sick urban communities, where the problems seem much more complex, and where in the past solutions have often succeeded only in creating fresh problems.

No easy victory

In a big Westernised city like Hong Kong there are no quick and easy health victories to be won. Thanks to an efficient Government there is safe water for all, sewage and garbage disposal, food market inspection, and immunisation programmes that have wiped out some diseases and reduced the lethality of others. Yet our urban communities are still sick, and this is reflected in hospital statistics for hypertension, peptic ulcer, attempted suicide, mental disease, accidents of all kinds, drug addiction, and cigarette-related disease. Who is going to diagnose the community sickness? Who is going to plan and execute treatment?

East of Hong Kong's airport is the new town of Kwun Tong. It attracts no tourists since it is overcrowded, badly planned, dirty, and unashamedly industrial. Close to 700 000 people live there, and nearly a fifth of all Hong Kong's products are manufactured there. The United Christian Hospital is the only hospital in the town (fig 1). It is an acute hospital and has been open for six years. It has 580 beds, whose average occupancy is now between 95% and 100%. Before it was off the drawing boards, we knew very clearly that an ordinary hospital of this size would be quite inadequate to deal with the needs of a community which is larger than Liverpool or Sheffield. It could not cope with the daily load of sickness, injury, and accident and certainly

United Christian Hospital.

United Christian Hospital, Kwun Tong, Hong Kong

E H PATERSON, FRCS, medical superintendent

could exert no influence at all on the general level of health in the community.

The hospital planning team decided, as one of its basic aims, to help the community to raise its health level. Hospitals are not normally designed to influence the health of their related communities, only to deal with sickness. But we felt that unless some attempt was made to "turn off the tap"—to reduce significantly the load of sickness generated in the community and raise the health level of the people—the hospital's services could never be more than a heroic rearguard holding action against the flood of ill health.

There is an old question: "Which is better, a superlative modern ambulance at the foot of a cliff, or a rough and ready fence at the top of a cliff?" We felt that in our situation both were necessary, but that ultimately the people at the top of the cliff had to learn to organise their lives so that they need not go near the cliff's edge. Our concept was a hospital programme co-ordinated with a community health service programme which would ultimately lead to people being concerned about raising their own health level—a hospital-based urban community health project.

Promoting community health

We had found in preliminary surveys that personal concern for the raising of health levels and acceptance of responsibility for the neighbourhood's health were not easy concepts for urban dwellers to accept. When we asked them what they wanted most in the way of health care provision, they replied in terms of extra clinics and more hospital beds. It was clearly going to take a long time to interest them in the community health idea.

We started by establishing three small health centres in the heart of neighbouring housing estates. A typical health centre has several thousand people living within a hundred yards. It provides general clinic and dental services, which are well used and need not be described further. These centres are also used as bases for other activities of the programme.

The most successful of these has been the community nursing service. Back in 1970 we started giving additional training to nurses so that they could learn to provide hospital quality care in people's homes. Along with a few other church-related hospitals and clinics we set up a community nursing service throughout the urban areas. The results were so impressive that the Hong Kong Government has now fully accepted the idea: it is giving full financial support to the programme, sponsoring training courses, participating in the service; and it intends to provide complete Colony-wide services in the next three years. In our own area there are at present 14 nurses based on the hospital and health centres who make 2500 home visits a month and add an effective 250 convalescent and long-term beds to our bed strength. Many of the patients are early-discharge cases needing short-term care, but a growing proportion are long-term cases whose care must be measured in months or years. The nurses not only carry out nursing procedures and make clinical observations. They must be prepared to give exercise therapy, social welfare advice, family health education, counselling to both patients and relatives, and training to all kinds of volunteer groups. They must be able to deliver their services in crowded resettlement blocks, squatter huts, boats in the harbour, or even holes in the ground. It takes a special kind of person to be a good community nurse, and we are fortunate in our team.

Health maintenance

A second concept which is being tested out is a series of health maintenance programmes. Our idea was to see whether regular contact between individuals and health professionals could reduce the incidence of disease and at the same time see whether enough health information could be passed on to the individuals to make them less and less dependent on the professionals. We

started with an infant health maintenance programme among babies born in the hospital. For a prepaid enrolment fee we provided monthly weighing and checking clinics, physical and psychomotor screening at stated intervals, advice on baby rearing, and easy access to clinic doctors when necessary. The mothers regard this programme as a great success and over 2000 enrollees are very satisfied. The trouble is that we do not reach the mothers who really need such a service—the inadequate, uneducated, or resentful mothers whose babies really need help. A schoolchild health maintenance programme carries out health screening and gives clinic and dental services and a limited amount of health education. An adult programme carries out annual screening: a completed questionnaire and the results of tests and x-ray examinations are discussed between doctor and client and a health plan for the year is drawn up, paying special attention to problems of overweight, oversmoking, signs of stress, or other factors needing attention. A geriatric health maintenance programme provides clubs for old people at which health education is given, medical screening is conducted, and notice is taken of the problems of old age. A last programme has been devised for industrial workers, but this has scarcely got beyond the clinic stage, as factory managers are reluctant to have our organisation concern itself with factory health and safety.

These health maintenance programmes have so far been funded to a large extent by a grant from a church agency in West Germany. This funding is nearly over and we are at present carefully evaluating the cost-effectiveness of each part of the programmes, looking to see where they fit in with Government programmes, and striving where possible to make them self-supporting.

Health education pervades every part of the project. We have a small well-trained health education unit, which produces material in the form of slides, tapes, posters, leaflets, displays, books, and games, and which also publishes a four-page monthly newspaper, the *Voice of Community Health*, which has a circulation of 15 000. Exhibitions and seminars are often arranged in partnership with local government and welfare bodies.

Community workers, who are trained social workers, are attached to each section of the work (fig 2). They study the reactions of the community and motivate them to accept more responsibility for their own health, enabling and encouraging the emergence of people's health committees, drama clubs, choirs, and children's organisations, and arranging in co-operation with other groups for festivals and celebrations, health weeks, senior citizens' weeks, and so on. The organisation of volunteer training is part of their responsibility though the actual teaching work may be done by others.

As a "logo" for this project, we chose a little "healthy man" with a round head and a three-pointed body (fig 3). This represents not only the idea of physical, mental, and social well-being

Community nurse in a squatter area.

contained in the World Health Organisation's definition of health, but also the three levels at which our health programme operates. These are the curing-caring level, the education-prevention level, and the level of positive health. By this last phrase we mean the growth, maturity, and self-fulfilment of individuals, families, and communities, through acceptance of responsibility for mutual health care, for free voluntary service to others, and for establishment of healthy mutual relationships.

The "Healthy Man" logo.

Hospital without walls

But what has all this to do with the building of a hospital? From the beginning we wanted to avoid the ivory tower image of a hospital, a professional enclave where the man in the street is a stranger. We felt there was a great need for a free flow of information and ideas from community to hospital and back, and we adopted the phrase "a hospital without walls" to describe our intention. We have not always been totally successful, since there seems to be something about medical people that encourages wall-building, but this still remains a basic aim of our organisation. Open days have brought thousands of people through the hospital's most hallowed areas, and tour parties

from schools, factories, and churches are welcomed. The community nurse service has done a tremendous amount to take concepts of cleanliness and care into people's homes, while in the reverse direction a large and well-organised volunteer service programme brings ordinary folk into almost every corner of the hospital, to bring a breath of the outside world to people imprisoned in the wards. A most important bridge between hospital and community is formed by our own domestic staff and porters. These people who work in the hospital's wards, clinics, laundry, and kitchen by day go home at night to the housing estates which surround us. We spend time and effort to help them to understand how important they can be in the two-way traffic of ideas and information. Each of our student nurses is now linked with a local family, whom she must visit regularly throughout her three years' training, so that she can understand how ordinary people react to health and illness, pregnancy, birth, and death. Some of our doctors rotate out to the health clinics and others accompany community nurses on occasional visits to people's homes. One most important service which the hospital needs to do is to sift through the enormous mass of clinical and epidemiological information we have, and tell the community what lessons they can learn thereby. It is one thing to talk in general terms about industrial safety, but if we can tell this community that within a 10-week period 12 of their own teenagers had fingers chopped off in industrial accidents, perhaps people will begin to feel that something needs to be done. What they do with the information is their own business. One day we hope they will begin to come together to take action against the roots of disease in their own midst.

One final point: the hospital itself is a miniature community. If it cannot turn itself into a model healthy community, what hope is there for the larger community outside? It is always on show, always under scrutiny, as a place where service is given, where learning and teaching are going on, where men and women face the realities of life and death. It should be a place of mutual respect and concern, mutual help, teamwork for health in the widest sense. That is why we need to build a hospital without walls so that the community we live in can create its own health.

MATERIA NON MEDICA

Closed shop

Over the third cup of coffee the orthopaedic registrar confided that the hospital mess was about to lose its unwritten contract with Hednesford Raceway to provide medical cover on Sunday afternoons since all the "bones people" were otherwise engaged the following weekend. As a mere medical registrar I made sympathetic sounds and poured the fourth cup of coffee. Then, as if it had just crossed his mind, he said,

"Of course *you* are a doctor; what are you doing on Sunday?"

"Come to think of it, nothing special," knowing as I spoke that I was letting myself in for it.

The mere fact that I possessed a medical qualification was, I was assured, all that was necessary. He grew enthusiastic; it was a cinch for £11 in cash for a Sunday afternoon—a drive out to Cannock Chase, a chat in the pits, and tea with the St John Ambulance Brigade.

"What about injuries?" I inquired nervously.

"Oh, nothing to worry about—they either kill themselves or break something."

Most reassuring! It appeared that I was required only to decide who went to the mortuary and who went for x-ray.

On Sunday it was pouring. I donned my denims and wellies, checked that I was still a member of the Medical Defence Union, and plodded down to Bed Bureau to collect the "emergency box."

Secretly I had hoped for a divine intervention between Wolverhampton and Hednesford, a medical catharsis which would orientate me traumatically. It didn't happen and I pulled up at the officials' entrance feeling ashen and bogus.

"Doctor from the Royal," I whispered. The man in overalls

looked incredulous and demanded my credentials. The gates then swung open and I was driving round the top of a large bowl—at the bottom a small race track, on all sides masses of people, and at the top a dirt track leading to parking spaces for official cars. With embarrassment I parked at the spot marked "doctor," and scanned the horizon wildly for the friendly Black and Silver Brigade. The noise was unbelievable—roaring engines, loudspeakers blaring the latest pop songs, and people shouting above the din. I lurched down the mud track to the vintage St John's ambulance. Within ten minutes I was drinking tea you could stand on and apologising to the friendly but surprised volunteers for the absence of the omniscient knife man. I was taken on a conducted tour of the pits by a youth called Ricky who slipped an oily arm round my waist and called me "luv." It was all too, too thrilling as I watched with a mixture of disbelief and fear while these strapping young men threw their suped up hot rods round the track. Somebody got something in his eye, my pulse rate soared, but a St John's stalwart threw a bucket of water in the chap's face and this treatment proved satisfactory. No further injuries occurred, to the disappointment of the ambulance driver who was dying to zoom out in the vintage blood wagon with siren sounding. More tea and I came to roost on the grandstand with my dog-eared copy of McCleod. The mysteries of mitral stenosis were soon interrupted by a new pop song requested by Ricky.

I reported back to the hospital mess, cash in hand, at 6.30 pm. Those sufficiently-conscious inquired how I had managed and how many disasters I had diverted to casualty.

"None," I replied. "It was fun and I want to go next Sunday," which I did, of course—PATRICIA LINNEMANN (ex-registrar, Wolverhampton).