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Proof in the Public

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The American health care system is flawed—many would say severely so. Perhaps instead of waiting for reform to come from the top down through broad-based policy suggestions, bottom-up solutions to the challenges of public health should be explored. Traditionally, such approaches are considered constrained in terms of resources and administratively opaque environments. However, the community health worker model, usually adopted as a last-resort practice in low-resource regions, has applicability and value even in apparently resource-rich spaces. These spaces could be college campuses, urban neighborhoods, or rural towns.

The community health worker, also known as a "barefoot doctor," is a community member trained in diagnosis, basic treatment, and health care practices. In many places in Sub-Saharan Africa, community health workers replace any semblance of a traditional health workforce for the majority of the population. Although at the situation is far from comparable in the United States at the national level, CHWs could revolutionize health care at the local level.

Several constraints to health care access exist, most of which are either economic or spatial. In impoverished urban neighborhoods, constraints are economic, whereas in rural small towns, health care facilities may be too geographically scattered to ensure access for all people. Lack of access to health care has been proved to adversely affect economic productivity and, of course, overall quality of life. Catastrophic expenditures on health care often force households that are on the brink of poverty into poverty and lock them into vicious cycles of reduced earning capacity and escalated expenditures.

Initiatives such as Project Health aim to harness the power of civil society, and specifically of undergraduates, to break the cycles of poverty and poor health. Undergraduates staff family desks in urban clinics and provide guidance to families seeking information about local resources not necessarily related to health—such as housing and employment. However, in a situation in which even health care professionals are scarce, services may have to be extended to basic health care and advice.

Therefore, in resource-constrained spaces, traditional tiered health care systems should be supplemented by informal organizations, coalitions, or even individuals trained in primary health care delivery. These informal groups or individuals would both constitute a lower level of service delivery and fill in the intersections and gaps in existing health care systems. Individuals entering the health care delivery system would bridge severe knowledge gaps between patients and traditional health care providers as well as ensure more personalized, decentralized, and accessible service delivery.

A governing and training organization could be formed—preferably under the aegis of a university—that would hire, train, and monitor the performance of such community health workers. Teams of workers would be assigned to the communities they wish to work with and trained according to the particular health needs of that community as demonstrated by its residents. The workforce would consist of a permanent paid staff of community health workers, supplemented by trained volunteers from the community and from the university (i.e. students). In East Harlem, certain pockets have poverty rates of over 50 percent, and organizations such as the East Harlem Health Outreach Partnership work to ensure access to basic health care services. The East Harlem Health Outreach Partnership was developed and is run by medical students at the Mount Sinai School of Medicine.

In terms of finances, informal organizations could be made self-sustaining by implementing community-based health insurance or a community-wide savings account. Pooling resources in insurance schemes or savings accounts would ensure that risk is spread out and would minimize the incidence of catastrophic expenditures. The affiliation of such a system with a university would ensure that it is trusted by the community and that there are resources in place to counter any financial shock.

In addition, these collective resources could be reinvested in the community itself, and so the health system could be coupled with initiatives such as the promotion of small enterprise. Health care could therefore act as a starting point for holistic community development.

Although centralized health care has its theoretical benefits, the insertion of decentralized service providers in the gaps left by centralized tier systems creates a "health care by all, for all" system. A decentralization of primary health care services would make health care accessible to the poor in the way that food is in a soup kitchen or clothes are in a thrift store—as it should be, given that it is a basic, fundamental right on par with food and clothing.

Yes, the system is flawed—severely so. But there is hope in the spirit of people to find simple solutions to the complex problems of a community. After all, these problems are symptomatic of those of a city, of a nation. Through civic involvement and initiative, the public can prove that one does not need a lofty podium or staggering oratory to make real change happen.