

# Choosing Healthcare in South Chicago: Information Strategies and Provider Choices

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## Introduction

We sat on the maroon plastic chairs neatly placed in a row in the waiting room of the South Chicago Maternal and Family Clinic. Time ticked, 1:00, 1:15, 1:30, and “People’s Court” blared on the television. A girl of about ten played Nintendo in the back of the room. In our hands were bags of colorfully illustrated pamphlets on the services offered by the clinic, about four pounds of it. We dutifully noted the comings and goings in our field journals. There was a roughly even mix of Latino and African American clients, predominantly women and children with a few men present. There was some coming and going among the clients as time passed, but persistently perched on the desk to our left was a piece of paper with the words “out to lunch” written in marker.

It was not particularly crowded, and the office was clean and well lit. Nearly every inch of wall was covered with signs or pamphlets. Some were posters on topics like healthy pregnancy and high blood pressure, some were missing persons flyers, and others instructions such as “how to wash your hands,” each alongside their Spanish equivalents. The preponderance of communiqués began their advisements with “NO.” No strollers beyond this point. No profanity. No eating or drinking. Do not go beyond this point until your name has been called. We were waiting for our first interview of our summer ethnographic field project, which was to be with Jerome,<sup>1</sup> a staff member, who was forty-five minutes behind schedule.

Jerome was busy pitching in to help clients because the clinic was short staffed. We later discovered that the Illinois Department of Public Health had cut its staff from

2,000 to 1,600 employees and was trying to “do more with less.” Public health personnel had very little time to devote to providing interviews. We were eventually granted several opportunities to have discussions with staff at the South Chicago facility after the initial attempt, but this first appointment was illustrative of the experience many residents have at the clinic, which has felt the recent cutbacks.

## South Chicago

South Chicago stretches south from 79th Street to 95th Street, and runs westward from Lake Michigan to South Chicago Avenue. This area was a center for steel and other manufacturing industries from the 1870s through the late 1960s. During the 1970s, layoffs began at the steel mills, and ended with the snuffing of the last remaining USX South Works smoke stack in 1992. This sent the neighborhood into an economic recession, which is still being felt today (Vaughn and Leslie 1995).

In 1890, half of South Chicago’s population was foreign-born. This community continues to be a gateway for immigrants, although the countries of origin are in constant flux and economic opportunities are fewer than what they were forty years ago (Vaughn and Leslie 1995). The newest immigrants to the area include Haitians, whereas immigration from Mexico has slowed in recent years compared to earlier influx rates. There has been an infusion of African Americans from other areas of the city, which has made African Americans the only ethnic group to increase as a percentage of South Chicago’s population

between 1990 and 2000, from 60 percent to 68 percent (US Census Bureau 2000). During the same period, the Latino population shrank from 34 percent to 27 percent (US Census Bureau 2000).

According to its 2003 Illinois School Report Card, 97.8 percent of the children at South Chicago's Arnold Mireles Academy are classified as low-income. However, there is hope for economic renewal. The 573-acre lakefront site of USX South Works is in the process of being sold and redeveloped with parks and new homes planned. It is within this neighborhood context that *Centro Comunitario Juan Diego* (Juan Diego Community Center) is taking steps to see that residents benefit from the development and are not simply displaced by it, while also fulfilling their primary goal of improving the community's health.

## Centro Comunitario Juan Diego (CCJD)

Incorporated in 1994 by a group of eight Mexican women, *Centro Comunitario Juan Diego* is a welcoming and inclusive grassroots organization. Most of the volunteers and staff are former food pantry recipients who live in South Chicago, and the executive director lives two blocks from the center. Particularly among Latinos, CCJD is known and trusted. A survey on healthcare was conducted by CCJD in early 2003, and within two weeks they collected 170 responses via their own network of volunteers and clients. Ninety-two percent chose to take the survey in Spanish, and only 18 percent reported being born in the U.S. Sixty percent of the respondents reported having no health insurance. The survey asked questions that were of a personal nature, including medical history and type of insurance. Eighty-one percent chose to give their names on this survey, 78 percent chose to give their addresses and 67 percent chose to give their phone numbers, demonstrating high levels of trust in the center.

CCJD offers a variety of services, including low cost car seats for children, a food pantry, free clothing, and asthma, diabetes and HIV/AIDS classes. They also provide English as a Second Language and computer classes for adults and children. They pride themselves on being able to provide these

services with very little funding because of their strong spirit of volunteerism and commitment to the South Chicago community. This earns them credibility because, as an organization, they are perceived as understanding the residents as they struggle with maintaining a low budget and making money stretch as far as they possibly can. Staff members have often taken pay cuts in order to preserve their programs. At the same time, this approach to finances distances them from other organizations, which are seen by CCJD as having very large budgets, yet providing less assistance to the community.

CCJD's core service is the *Promotores de Salud* (Health Promoters). The health promoter model of care is active across the United States and in Latin America within communities that lack full access to traditional health care. Under this model, local people are educated about various health issues and trained to disseminate this information and, in some cases, actually treat and screen fellow community members. Health promoters are also called community health workers, community health advocates, lay health educators, community health representatives, peer health promoters, community health out-



photo by Maria Campos

reach workers, and in Spanish, *promotores de salud*.

At CCJD the *promotores* are trained by professionals from organizations like the Red Cross, the Indian Health Service, the American Lung Association and the Chicago Department of Health. This type of intervention

addresses the immediate need for culturally and linguistically competent healthcare workers. People who belong to traditionally marginalized minority groups are more likely to trust information from people in their own community, rather than outsiders. This is due to an insider's ability to operate within the cultural framework and communicate with the people they are servicing. The *Promotores de Salud* engage in direct outreach by doing presentations and going door-to-door to learn the needs of community members. "When you're in their home, they talk to you like a friend," said one health promoter. "It's better because they are more comfortable and will open up to you more about their needs."

## Methods

Our research was conducted during a nine-week summer internship at the Field Museum's Center for Cultural Understanding and Change (CCUC) as part of the 2003 Urban Research and Curriculum Transformation Institute. The museum partnered with *Centro Comunitario Juan Diego* to develop research questions important to community health and advocacy in South Chicago. Through a series of meetings with CCUC staff, it was decided that the research program would explore how people were getting healthcare information, making choices and evaluating the care they received in South Chicago.

We used a combination of participant observation, semi-structured and structured interviewing as our data collection methods. We were able to contact the majority of the participants vis-à-vis their participation in CCJD programs while some impromptu interviews were conducted with people who were already at CCJD. Interviews were generally held in a private location that was conven-



photo of interns and partners by Ivan Watkins

ient to the participant. In addition to CCJD as a source of informants, a local job-training program allowed us to contact their program participants. Ericka's interviews averaged fifteen minutes and were conducted with twenty-seven adults and one child (who acted both as interpreter for her mother and respondent) from the South Chicago area. Ericka conducted interviews in English, twice with a Spanish translator, which limited the sample of her potential respondents to individuals with fluent or nearly fluent English skills. Interviews were conducted in a conversational style. Respondents were first asked a series of open-ended questions about their healthcare choices and history of experiences, and then four basic areas of healthcare were explored: home healthcare, emergency care, chronic care and wellness. Table 1 shows the demographic breakdown of the people with whom we held semi-structured interviews. Because it is one of the most important factors in determining where individuals go for healthcare, information about insurance coverage among our respondents is also included in Tables 1 and 2.

**TABLE 1: Semi-Structured Interview Respondents (N = 28)**

Median Age	40
Median Years in South Chicago	8
Sex	36% Male 64% Female
Race, Ethnicity and Nationality	12 African American (All U.S. Native) 10 Latino 7 Mexican (4 U.S. born and 3 Mexican born) 2 Puerto Rican 1 Unknown 4 Haitian 1 White (U.S. Native) 1 Arab (Palestinian from Israel)
Immigrants	39%
Insurance (discussed with 25 respondents)	13 Governmental Insurance Programs 4 Illinois KidCare 1 Medicaid 1 Medicare and Medicaid 3 Public Aid Medical Card 2 Public Aid Medical Card and HMO 4 Private Insurance 6 No Insurance, 24%

Andrea focused on structured interviews, which averaged five minutes. These interviews were conducted in various locations. The majority took place on the streets, and the rest were conducted inside local grocery

stores, laundry mats and Walgreens. Participants were asked a series of open-ended questions with direct focus on perceptions of health, healthcare choices and healing techniques. Most of the interviews were in Spanish and translated into English by Andrea. Table 2 shows the demographic breakdown of the individuals who participated in structured interviews.

**TABLE 2: Structured Interview Respondents (N = 53)**

Median Age	38
Median Years in South Chicago	4.5
Sex	30% Male, 70% Female
Race, Ethnicity and Nationality	46 Latino 40 Mexican 1 Ecuadorean 1 Guatemalan 4 Unknown 8 African American (All U.S. Natives)
Insurance (discussed with 50 respondents)	66% uninsured

Because of our sampling methods and primary contacts, as well as the gender and ethnicity of the researchers, both women and Latinos were heavily represented as a proportion of the sample size for our research. Therefore, our findings should not be considered representative of all groups within the community. A statistically random and representative sample, although desirable, would not guarantee the types of information we were seeking. Within the parameters of this research project, our focus on the available people with whom we shared some measure of rapport and trust, either due to our common background or our association with CCJD, was an effective means of obtaining data that provide interpretative value. The sensitive nature of medical information requires some measure of trust and this was valued more highly by the researchers than the demographic profiles of respondents.

**TABLE 3**

Total Respondents (N = 81)		South Chicago, 2000 Census Data (N= 38,608)	
Age	68% under 44	Age	71% under 44
Sex	68% Female 32% Male	Sex	54% Female 46% Male
Race/ Ethnicity	25% African American 68% Latino 7% Other	Race/ Ethnicity	68% African American 27% Latino 5% Other

As we became more familiar with the healthcare system, South Chicago, the existing literature and our initial research findings, we focused on the following questions:

- How are South Chicago residents getting information about health and wellness care, and how are neighborhood organizations disseminating information about their services?
- When services are available, how are people making decisions? What is the perceived quality of care?
- Where are people in South Chicago getting health-care?

## Finding Out About Healthcare Options

Data were collected on how people received information about the healthcare services that they currently use. We observed several instances where people found out about healthcare services through referrals or signage. Asking how an interviewee found out about a certain service was extremely important, considering how much money and time is spent on disseminating information about services. We wanted to find out more about what forms of outreach are most effective in finally convincing a person to use a medical service that they may or may not have heard about before. This aspect of our project could be conceived of as market research for medical services.

Both the service providers and the residents agreed that there was a lack of reliable health service information in the community, particularly for local services. Some residents believe that more outreach needs to be done, while some service providers, due to shrinking budgets, have made budget cuts to preserve core services. Many local services, including those of CCJD, depend on short-term grant funding from private and government agencies, which can be an unstable source according to many such organizations.

Many of the residents who have attempted to educate themselves on the available healthcare options indicate that services promoted in literature distributed within the community are actually more limited than what the material suggests. For example, many services are unavailable to undocumented immigrants or they require so much paperwork that most potential service recipients become frustrated with the bureaucracy and simply give up. Other services are promoted, yet when

potential patients come to the provider they are not told about the service. Discouraging experiences like these have resulted in patients feeling they need to “stand up for their rights.” This means arguing with the service staff about perceived unreasonable policies, and with doctors about the quality of their care. Those who adopt this stance seem satisfied that it is effective. One lifetime South Chicagoan who was disabled said:

You have to speak up for your rights. I had one doctor there [at Mercy Hospital] and every time I asked about some kind of new treatment he responded negatively, and I said, ‘why do you always respond negatively’, and I was upset. So then Dr. Williams came in and he said he’d be my new doctor. He listens to me.

Despite challenges, the people we spoke with were getting information and choosing among the healthcare options available to them.

## Word of Mouth

Most commonly, people found out about a service they now use through direct interaction with another person whom they know. Friends or family who actually used the service in question were the most frequently cited sources of reliable information. This involves a slow process of building trust between many individual clients and the service provider so that the client will feel comfortable recommending the services he or she receives to friends and family. Only long established services enjoy this free and effective form of promotion.

One well known health service option is Cook County Hospital, which has been operating in the Near West Side for over a hundred years. Despite being located fourteen miles away from South Chicago, Cook County Hospital is so well known to members of this community that when Ericka asked people how they “found out about” it, she got a few baffled looks. One man who has lived his whole life in South Chicago said he has been going to Cook County Hospital since he was born. “You know, my mom not being on my father’s insurance,” he explained, “[Cook County] is a ways to go, but it’s free.” Because publicly-funded Cook County Hospital is required to help those in need even if they lack insurance, positive word on the street serves as its own advertising

campaign. The South Chicago Clinic (SCC) is another facility that does not formally advertise its services or publicize a health agenda within the greater community. People are likely to find out about SCC through word of mouth, including doctor referrals, or simply passing by it.

## Provider-Initiated Outreach

Many different strategies are used to promote healthcare services, which vary dramatically from organization to organization. El Valor’s Children and Family Center in South Chicago, for example, uses health fairs, flyers, videos and community partnerships with other organizations to get the word out about their services, which include Head Start daycare facilities, health screenings and parenting classes. Staff members of El Valor are also active on the boards of other organizations and they spread the word about their programs through this network of service providers.

Several respondents indicated that they found out about services through promotional efforts of the provider. Some of these sources include television commercials, health fairs and announcements at church. Flyers were not cited by anyone as the primary way they found out about a service they use. In several instances, flyers were mentioned in conjunction with word of mouth interactions or announcements as auxiliary aids to finding the service.

Among participants interviewed, we found that people were just as likely to have “walked by” local services as to have found out by all provider-initiated promotional efforts combined, including flyers, announcements and health fairs. The simple act of having a presence at street level with a sign out front and a receptionist is a powerful marketing tool in this community. Although it was beyond the scope of the research project to determine why this is the case, the research findings suggest that organizations should use their exterior space to the fullest to take advantage of passersby, which would increase walk-in utilization of services.

## Making Decisions

### *What is Healthcare?*

It is common to think of healthcare providers as limited to modern Western medical facilities that treat disease,

such as the doctor's office, the hospital or the clinic. However, our focus was more holistic. The grocery store and the food pantry that provide nutrition are a component of health care. There are over the counter medications, home remedies and traditional healers to consider, as well as health education, outreach and exercise. Indeed, within South Chicago, these additional factors may play as important if not more important a role than traditionally recognized avenues of health care. Our objective was to see which facilities, both inside and outside South Chicago, were being used by the residents and why. Our study was a preliminary step in understanding how people in this community conceive of health, how they find out about health information and how they make healthcare decisions.

### What is Health?

According to the Chicago Department of Public Health's website, "Health is more than the absence of disease. Health is physical, mental, and social well-being." But this

definition is not intended to be, nor is it actually a reflection of the public view. For the vast majority of our sample, being healthy simply means that one feels good and is able to perform daily activities such as work. This finding is supported by prior research conducted in a Mexican-American community, which states that health is associated with a state of being and directly translates to feeling free of pain, being able to perform one's activities and being happy (Torre 2001).

Our findings for African Americans and Latinos in the community were largely similar. The concept of health as a condition of moment-to-moment wellness may explain several incidences where we had people telling us, "I'm a healthy person" even though in one case, the person had suffered a stroke, continued to have high blood pressure and obesity, was anemic and had lost or pulled all of her teeth. The public and the health professionals are working with two different definitions of what a healthy person is, and this disjuncture must be recognized before such a gap can be bridged.

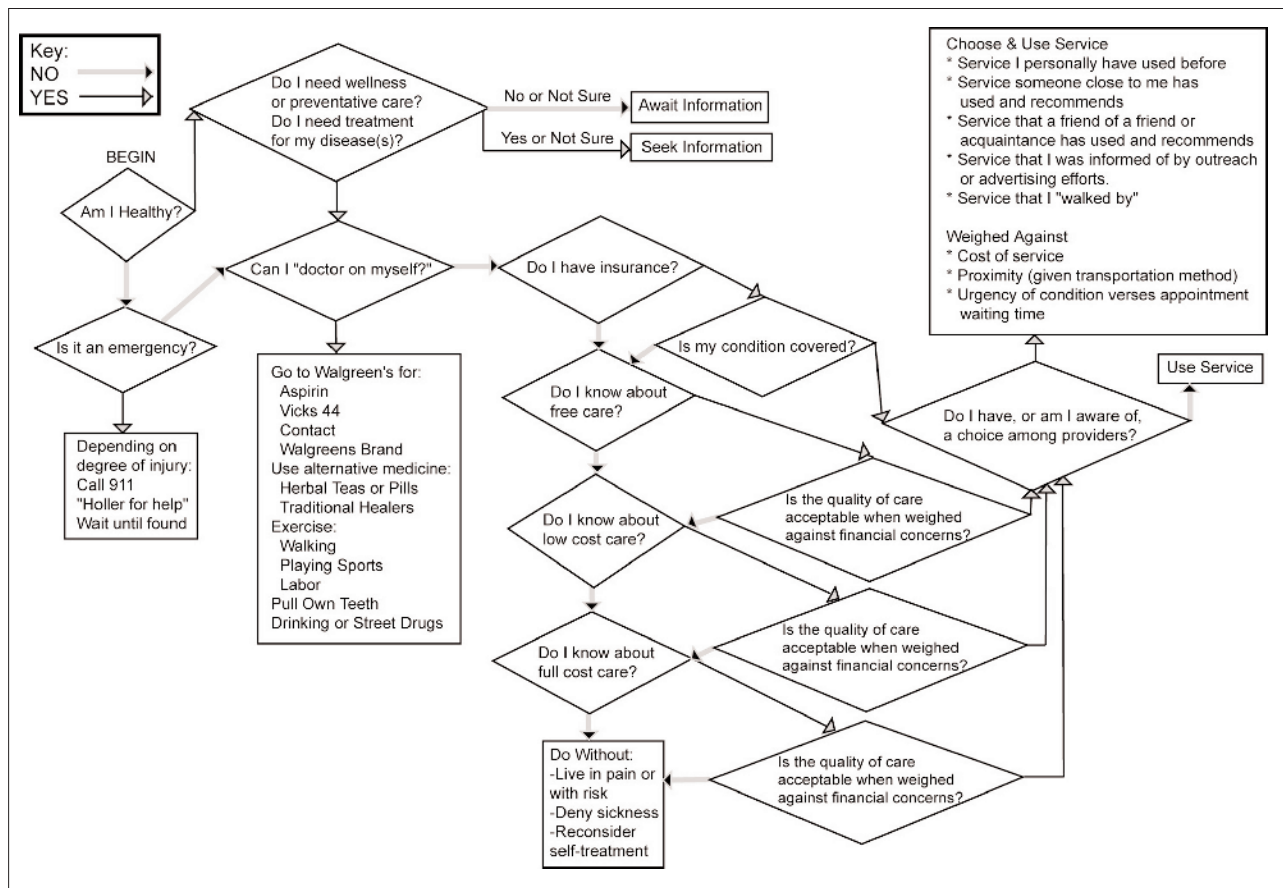


Figure 1: The health decision-making process for South Chicagoans<sup>ii</sup>. figure by Ericka Menchen and Andrea Rincon

## *Prevention*

Another decision that people make concerning their health, within the limitations imposed by larger socioeconomic forces, is whether to engage in prevention-related efforts. The Chicago Department of Public Health wants to spread the message that people can stay healthy if they use preventative care. This has been, and will continue to be, a very difficult message to communicate. Changing the public's perception of what health is and what it means to be healthy cannot be done only from "the top down," but must include "ground up" efforts as well. The intended audience for these public health messages must be involved in their dissemination because of the fundamental change in perceptions of health that is required.

We found that the majority of people we came in contact with were awaiting information, as depicted in Figure 1. They feel that they are healthy because they may not be experiencing an illness at the time. They are not actively seeking treatment or further information on health. They may know that they are overweight, or have high blood pressure, or that they should have a mammogram and would be receptive to information about these issues, but they do not consider themselves "unhealthy." They simply may not have the mental energy to take on another problem, even if they are informed about the connection between unhealthy habits and long-term health effects.

Socioeconomic factors also have a direct negative impact on the health of the poor. A visit to the clinic, an all day affair, is to be avoided because as much time as possible is needed for work. "The only thing that I want is to be healthy so I can go back to work," said Jose while recuperating from a work-related injury. Research shows that "low-income, substandard housing, inadequate or unsanitary living facilities, lack of formal education...discrimination, poor nutrition, and stress can and do affect the health of Mexican Americans" (Torre 2001:25). Improvement in the economic conditions would have a direct benefit on the health of residents.

One of the most significant health problems for minority communities today is obesity. During our research, Mexican immigrants, in particular, reported problems maintaining a healthy weight in the United States. This has also been the experience of many immigrants who work or volunteer at CCJD. They cite the

freshness of food in Mexico and the lack of preservatives in contrast to dietary choices here. A recent survey of South Chicago grocery stores found that out of twenty-eight stores selling food, only nine sell fresh fruit and ten sell fresh vegetables, but the majority of stores sell neither (Ramirez 2002). Obesity "is a primary modifiable risk factor for the development of diabetes, heart disease, cerebrovascular disease [stroke and high blood pressure], and cancer" (Torre 2001:33). Organizations, including CCJD and Health South Chicago, are addressing this problem by attempting to educate South Chicago residents about responsible dietary practices. CCJD targets obesity with nutrition education, exercise classes and preventative screening. One program is promoting healthy recipes using healthy Mexican foods such as nopales (cactus).

## *Self-Treatment*

Based on the interviews we conducted, the first preference for treatment of non-emergency conditions was some form of self-treatment, sometimes referred to by African Americans as "doctoring on myself." Depending on the condition, self-treatment ranged from lemon tea with honey (the most frequently cited cold remedy) to pulling one's own teeth, to alcohol and drug use. Walgreens was often mentioned by name as the primary retailer where self-treatment remedies can be purchased.

If the individual perceives their condition is serious and feels that additional treatment is needed, they will most likely seek the care of a doctor or nurse. Initially we hypothesized that the use of alternative medicine would be prevalent in South Chicago because of insufficient medical services. However, the people we talked to said that they primarily use private doctors, clinics and/or hospitals to treat disease and illness. Several interviews with administrators in the public health system in South Chicago indicate that despite the recent cutbacks, medical services still are available for a substantial proportion of low-income and undocumented residents. Most people reported not knowing any local healers and not using herbal healing techniques, except in the case of colds. This finding applies to all participating ethnic groups.

We did find a few residents who use alternative medicine, including some of our primary contacts, but not to the exclusion of Western medicine. There is a possibility that people did not feel comfortable telling us that they

**Table 4: Frequently Accessed Facilities**

Name	CTA Route/Miles (from center of South Chicago)	Payment & Service Information
Chicago Family Health Center 9119 S. Exchange Ave.	In South Chicago	Sliding Scale Available, Non-emergency care
South Chicago Clinic 2938 East 89th Street	In South Chicago	Sliding Scale Available, Non-emergency care, only pediatrics and women's health
Cook County Hospital 1901 W. Harrison Street	Downtown Chicago, CTA: 87 bus to Red Line @ 87th to Jackson, to Blue Line Forrest Park to Medical Center and walk South 1 block 14.06 miles	Free to those without means, Emergency care, surgery, specialists
Advocate Trinity Hospital 2320 East 93rd St.	In neighboring Calumet Heights CTA: 27 bus 1.4 miles	Private Hospital, charges more to those without insurance. Emergency care, surgery, specialists
<i>Centro Comunitario Juan Diego</i> 8812 S. Commercial Ave.	In South Chicago	Almost all services are free

used alternative medicine because key informants with strong ties to the community stated that alternative medical practices are very prevalent.

## Where People Go

South Chicago is very much a part of the city. Several Chicago Transit Authority busses, two Metra commuter rail line stops and a nearby highway provide transportation to downtown. Although feelings about the adequacy and availability of transportation vary, many residents travel to other locations on the South Side and downtown to receive healthcare services. People travel to use these services for a variety of reasons, including cost, quality of care and continuity of care. Because we found that the majority of residents use hospitals, clinics or private doctors, we began documenting specific information about the facilities and services being used. Table 4 lists the four facilities most frequently accessed by residents according to our research.

The facility most frequently visited by the people we spoke to was the Chicago Family Health Center (CFHC). We found the CFHC to be a more likely facility for Latino people to visit if they are ill and seeking professional medical attention in our sample than other clinics or hospitals. The staff and doctor at CFHC speak Spanish fluently, and Latino clients claim that they are satisfied with the care they receive at this facility. Another advantage of CFHC to members of the Latino community is that their sliding scale program does not require patients to provide a

Social Security number, which opens the door for undocumented and low-income immigrants to receive care. Among our sample, diabetes care was the most frequently used service of the clinic. Reports of the quality of care received at CFHC varied greatly, from “very bad treatment and I’ll never go back,” to “very good, they are nice there.” Our interviews and survey data collected by CCJD indicated that overall satisfaction was better for CFHC than all other facilities discussed by informants.

The South Chicago Clinic (SCC), part of the Chicago Department of Health, was also frequently cited as a preferred non-emergency care center by the respondents to our survey. Our data shows that African Americans are happier with SCC’s services than are Latinos. SCC’s staff is mostly African American, and so are two of their five physicians. (Two physicians are Pacific Islanders and one is European.) Studies have shown that “racial concordance between patient and physician is associated with greater patient satisfaction and higher self-rated quality of care” (Betancourt and King 2000:871). Several people we talked to complained about extremely long waiting periods for appointments and in the office. Most patients we interviewed said that their average wait was between two and four hours after they had arrived for their appointment, and this was confirmed by the survey done by CCJD. The SCC’s staff members are aware of this persistent problem and are trying to make administrative changes to solve it.

A key resource and “safety net” for the poor throughout the city is Cook County Hospital. It is the



opinion of the vast majority of patients that County has good doctors, but waiting, especially with an emergency, can be a very painful and traumatic experience. Yet the uninsured have few other options. “I waited from six at night to eight a.m. in the emergency room of Cook County with a broken leg,” said one CCJD staff member and longtime South Chicago resident. Access to care at Cook County Hospital is very limited for new patients. The waiting period for a first time non-emergency appointment was three months at the time of this study.

Advocate Trinity Hospital (Trinity) was the emergency facility most frequently visited by participants in the study who had insurance. Although it is not within the boundary of South Chicago, it is the closest hospital and most accessible for residents taking public transportation. We found both positive and negative evaluations from Trinity patients, but the majority of respondents had negative opinions about the care they received there. The negative comments were not generally limited to the administrative staff as they were with most other facilities, but included misdiagnoses and poor bedside manners on the part of the doctors. Javier, a volunteer at CCJD said, “They treat you like nobody. My daughter had a neck pain, you know kids, so we took her to the hospital and the doctor said ‘What are you wasting my time for? There is nothing wrong with her.’ But she was in pain, so we went to the clinic (CFHC) and they gave her a neck brace to wear for a few days and some drugs.”

*Centro Comunitario Juan Diego* does not provide direct treatment services, but it does serve as a key health resource for its clients. They focus on education, prevention and try to provide screening services for diseases such as HIV/AIDS, diabetes, high blood pressure and breast cancer by partnering with local hospitals and clinics. Latinas in particular feel comfortable at CCJD because the majority of the staff and leadership are from their ethnic group. Because CCJD was our base of operations, a much greater proportion of the people we talked to knew and used CCJD’s services than the community-at-large. The general feeling of CCJD leadership was that most people on the street do not know about them, but among those who do know of them they are well regarded and trusted.

Other facilities include the University of Chicago Hospitals, Michael Reese Hospitals, South Shore

Hospital, Jackson Park Hospital, the South Chicago YMCA, the city clinics in Roseland and Englewood, and several private doctors and dentists. Our research found that people go far and wide to seek medical care for a number of reasons. New residents wanted to keep their doctors who were located in other parts of the city from which they had moved. Long-term residents had seen their doctors move to other areas, and some had become “fed up” with local facilities. Healthcare decisions are complex and each individual weighs the variables differently (see Figure 1).

## Medical Insurance, Provider Choices and Obstacles

The people of South Chicago have limited options for treatment due to restrictions within their insurance policies (including government programs and HMOs), lack of physical mobility, lack of money (for treatment and transportation), perceived lack of quality care at particular providers, lack of information and language barriers. There are many government programs intended to provide insurance for those with low incomes, and the majority of the semi-structured interviewees had health-care coverage under some form of government-sponsored insurance plan. There are also many people who do not fall into the categories of income and parental status, or lack documentation that would enable them to qualify for these programs. Others we interviewed do not know about health programs available to them or prefer not to use government services.

Several times uninsured participants in the study told us that they have one provider option, Cook County Hospital, which is used in the case of an emergency. Although other facilities will take them, there is usually at least a minimum payment required up front before services are rendered, and some places, such as the Advocate family of hospitals, charge the uninsured much more than they charge insurance companies, who have collective bargaining power (Knowles 2003).

Some individuals combine both public and private insurance by using HMO programs that are available to supplement the coverage provided by public aid, although evaluations of the effectiveness of this type of coverage are mixed. One woman, who consistently calls

the HMO 800 number to seek information about which doctors to see, stated she is very happy with her coverage. Another woman, who felt she was signed up for the HMO against her will, indicated she was upset with the restrictions on where her primary care provider is located.

One longtime South Chicago resident was amazed at the difference a (PPO) medical insurance policy made in terms of her access to care. “I got insurance two years ago, and I never had it before,” she said. “Now that I have it all the doctors are lining up. For my shoulder, no one wanted to see me. Now everyone wants me. I get letters from University of Chicago and Trinity wanting me as a patient.” Because insurance is such a strong determinant of healthcare access, impartial guidance on insurance options is needed in this community where many residents qualify for government subsidized programs.

In addition to insurance related issues, healthcare providers in South Chicago face the extra obstacle of caring for a population in tremendous demographic flux. Undocumented immigrants, said one community expert, stay an average of three years before returning to their country of origin or moving out of the area. Although it is difficult to estimate the number of undocumented immigrants in South Chicago, undocumented workers account for approximately 5 percent of the Chicago metro area labor market and represent a growing segment of the low-wage workforce (Mehta et al. 2002). The Chicago Housing Authority has also been seeking to decentralize public housing by tearing down large high-rise facilities and offering vouchers that can be used around the city for rent (CHA 2003). This has led to an infusion of former high-rise public housing residents to South Chicago. The constant fluctuation of services offered and the residents themselves make the information flow less seamlessly than in more affluent and stable neighborhoods.

Language barriers also present significant challenges for some residents. Cook County Hospital, for example, lacks sufficient bilingual staff. On one occasion, when Andrea was working at CCJD she overheard Laura, a staff member, being hung up on by someone. She asked Laura what was going on and she said that she was trying to schedule a new date for her surgery, which had been canceled. The staff member at Cook County hung up on her because Laura only speaks Spanish. Andrea offered to translate for her, called the hospital and talked to an

extremely unhelpful person who said that nobody on staff was bilingual and no one could help Laura reschedule over the phone, even with a translator. The obstacles to effective healthcare, including a lack of resources (e.g. insurance), a changing population, language barriers and frustration within the community are clear. In spite of these barriers, people are actively pursuing the improvement of their health when they feel treatment is needed.

## Recommendations and Conclusion

As residents and healthcare services undergo constant change, the lack of complete and timely information about the nature of these services in the community will continue to be a challenge. However, appropriate interventions—grounded in people’s existing information-gathering strategies—can help to improve the situation. Based on our research, we recommend that services make full use of the communicative potential of their exterior space. Bold, bilingual signage with very large type containing few words and readable by a casual passerby from the sidewalk may catch the attention of those “awaiting information,” whereas smaller flyers, which require a close reading on the part of the recipients, may not. Flyers can be important secondary sources of information for individuals interested in receiving healthcare information, but should be distributed from within the doors of the facility. More importantly, bilingual staff must be available to competently answer questions about the services provided at the facility.

Once people find out about their options, the decision-making process can be very complex with many personal factors weighed. People often consider themselves healthy even when they have been diagnosed with a disease, as long as they do not feel ill and are able to perform day-to-day activities. Many people feel that unless they are physically impeded by illness, their health is not a priority compared to other struggles they face on a daily basis. The healthcare decision-making process is only important to them when daily activities are affected.

The majority of South Chicago residents use some form of self-treatment as a first option and some may use alternative medicines, but our findings in this area were inconclusive. Many travel long distances to other facilities when local services are perceived as inaccessible or unde-

sirable. Most Latinos go to Chicago Family Health Center because they have bilingual staff and their sliding scale program does not require a Social Security number. SCC was often preferred by the African American population we sampled, possibly because of the racial concordance between patient and physician/staff. Cook County Hospital and Advocate Trinity Hospital were also frequently mentioned as important emergency resources, but were criticized for long waiting periods and staff who have difficulties effectively communicating in a multilingual environment. Although transportation is perceived as a problem for many, there are other clinics and hospitals used by South Chicago residents across the Chicago area.

Our research findings indicated that most South Chicago residents consider health to be a condition of the moment, over which they have little control. Most informants did not expend much effort on preventative care or disease treatment if they considered themselves healthy. For the layperson, health is not the long-term holistic conception that health professionals tend to use. Getting the word out about specific prevention efforts is one way to begin the process of changing common perceptions about healthcare. Human interaction is key to the promotional effort because people trust word of mouth more than other methods of information dissemination. In South Chicago, *Centro Comunitario Juan Diego* is one community organization that is taking steps to empower residents in their healthcare decisions through educative outreach and personal connections.

## Bibliography

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- Betancourt, Joseph R., and Roderick K. King  
2000 Diversity in Health Care: Expanding our Perspectives. *Archives of Pediatric Adolescence Medicine* 154 (6):871-872.
- Chicago Department of Public Health  
n.d. Electronic document, <http://www.ci.chi.il.us/Health/Mission.html>, accessed November 11, 2004.
- Chicago Housing Authority  
2003 Annual Plan for Transformation FY 2003. Electronic document, <http://thecha.org/transformplan/plans.html>, accessed November 11, 2004.
- Knowles, Francine  
2003 Area Hospitals Bill Uninsured at Higher Rate. *Chicago Sun-Times*, May 26: 47.
- Mehta, Chirag, and Nik Theodore, Iliana Mora, Jennifer Wade  
2002 Chicago's Undocumented Immigrants: an Analysis of Wages, Working Conditions, and Economic Contributions. University of Illinois at Chicago. Electronic document, [http://www.uic.edu/cuppa/uicued/npublications/recent/undoc\\_full.pdf](http://www.uic.edu/cuppa/uicued/npublications/recent/undoc_full.pdf), accessed November 11, 2004.
- Ramirez, Dinah  
2002 Community Assessment Report. Chicago: Healthy South Chicago.
- Torre, Adela de la, and Antonio L. Estrada  
2001 Mexican Americans and Health: Sana! Sana! Tucson: University of Arizona Press.
- United States Census Bureau  
2000 Electronic document, <http://www.census.gov/main/www/cen2000.html>, accessed November 11, 2004.
- Vaughn, Sharon, and Annie Ruth Leslie, eds.  
1995 Local Community Fact Book Chicago Metropolitan Area 1990. The Chicago Fact Book Consortium, University of Illinois at Chicago.

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i All names have been changed. Some quotes edited to maintain anonymity.

ii Figure 1 represents the typical healthcare decision-making process for the South Chicago residents we interviewed. If the interviewees felt they were healthy, they would passively accept health information, but generally not seek it. If the interviewees were not healthy, the first consideration was the severity of the illness. If it was considered very serious, such as a likely broken bone, most said they would call 911 for an ambulance. If it was not considered very serious, self-treatment options were considered. If the condition did not respond to self-administered treatments or if the illness was more severe, the person would seek further medical attention. The person's level of insurance coverage is the primary determining factor in assessing costs. After the cost decision comes the process of finding out about providers as described above. Lastly, people make a decision and receive care.