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Putting Care Back into “Health Care:”
An Analysis of the Place of Community
Health Workers within the U.S. Health
Care System

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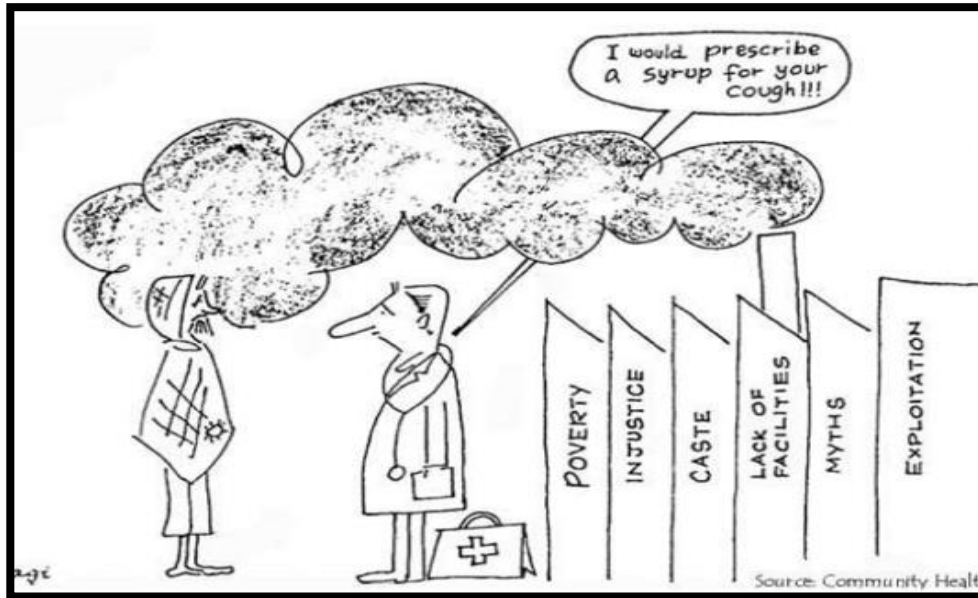


Figure 1: From “Health, Culture & Community,” *International Honors Program School of International Training*, Fall 2015

INTRODUCTION

The day was heavy with humidity. Storm clouds eerily crept in from the distance. Yet not even the weather could stop Carol from showing me the community she served and the neighborhood sidewalks she walked every day. Carol was a community health worker (CHW) for a primary health center called Barra Funda located in downtown São Paulo, Brazil. She was going to show me exactly what being a CHW meant to her by allowing me to shadow her during a typical day of work.

After grabbing minimal medical supplies such as a stethoscope and over-the-counter pain killers, Carol and I left the primary health center to begin the daily rounds and meet her

community members. We crossed a busy street in front of the health center and walked a few blocks before finding ourselves located at the beginning of what she called her “care district.” Carol explained how she did not check every house within her care district each day. Instead, she created a list that prioritized which neighbors she should tend to first. Often, pregnant mothers were on the top of her list, followed by individuals with illnesses requiring daily prescriptions, and finally palliative care patients. Carol explained how the prioritization of patients in her job was required to ensure that every house in the care district had access to the health resources needed to guarantee their well-being. Before even reaching our first stop for the day, Carol was greeted by many community members. A few parents asked her about the storm approaching and whether or not it was safe for their kids to play outside much longer. It was clear from these informal interactions that people in the community had a relationship with Carol and they trusted her with their questions.

Our first destination that morning was home to a mother who had recently given birth. Carol wanted to make sure that the baby was doing all right and that the mother was able to breastfeed with her child. The mother had been expecting Carol and greeted her at the door before proceeding with the baby’s check up as planned. The entire encounter was very natural and felt like friends taking care of one another. After only fifteen minutes or so, Carol made sure to ask if the mother had any questions or concerns for her to report back to the health center before we continued on with our walk through the neighborhood.

Shadowing Carol in the community around Barra Funda Primary Health Center was my first introduction to the notion of a CHW. Prior to traveling to Brazil, the concept of CHWs was unfamiliar to me. I had never heard of CHWs within the U.S. and assumed they were only a unique component of the Brazilian health system. After returning home, I realized that one need

not take a tour of an inner city primary health center in São Paulo, Brazil to find CHWs hard at work. From various Internet searches and conversations with health practitioners in WA, I learned that over 10,000 CHWs work daily in U.S. neighborhoods and that 22 college-based programs certify CHWs across the country.¹ These numbers led me to wonder if the CHW held a different role in the U.S. compared to what I had seen in Brazil due to the distinct variations between the two country's health systems and my initial unawareness of CHWs. So began my quest to understand the place of CHWs within the context of the U.S. health care system.

Two questions have guided my research concerning CHWs. The first question examines how CHWs fit within broader themes relevant in the field of Science, Technology, and Society: In what ways can health resources become more accessible for populations lacking sufficient health care? Ultimately, I am looking at the relationship between scientific authority (i.e. medical professionals) and the public (those dependent on the health care system) and the way information and resources are exchanged from one population to the next. The question's form assumes, of course, that the resources and knowledge health professionals hold are not adequately distributed to communities in need and that there is a gap between the knowledge held by the health system and people dependent on the system. This leads to my second question: How do CHWs see their own roles/responsibilities within a community and what can their visions tell us regarding the current gap within U.S. health care? I will look at studies and reviews of CHW programs across the country in addition to personal experiences with CHWs to highlight the shortcomings of the U.S. health system in reference to CHW programs. By identifying the contributions CHWs make to the U.S. system, I will identify the services that are missing from U.S. health care according to the underlying values and assumptions of the CHW

¹ Kristine Goodwin and Laura Tobler, "Community Health Workers," *National Conference of State Legislation* 1 (2008): 10.

model. Both research questions are considered in conversation with one another throughout the course of this paper to highlight the broader health reform movements that are embodied within CHW services.

MAIN THEMES WITHIN THE U.S. HEALTH SYSTEM

To begin, it is helpful to describe the main characteristics of the U.S. health system to provide context for ideas that will reemerge throughout the paper. In general, U.S. health care is Western such that it results in highly individualistic, reductionist and biomedical oriented care. Medical historian Roy Porter captures the essence of Western thought applied to medicine when he writes, “the West has evolved into a culture preoccupied with the self, with the individual and his or her identity, and this quest has come to be equated with (or reduced to) the individual body and the embodied personality, expressed through body language.”² In other words, the West, which includes the U.S. and Europe, has developed “radically distinctive approaches to exploring the workings of the human body in sickness and in health.”³ For example, U.S. approaches to health care are deeply rooted in the mechanistic conception of life and the reduction of the human body into parts and places of illness compared to alternative medicine, which deals with illness as a disorder affecting the patient as a whole within a greater environment.⁴ The mechanistic approach to medicine holds the perspective that the human condition, including human feelings and thought, are natural phenomenon that are explained scientifically by means of biological mechanisms, or smaller parts of a larger machine. Porter writes how literally “the idea of probing into bodies, living and dead (and especially human

² Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York, N.Y., United States: W.W. Norton & Company Inc., 1997), 7.

³ *Ibid.*, 8.

⁴ James Whorton, *Nature Cures: The History of Alternative Medicine in America* (Oxford University Press, 2004), ix.

bodies) with a view of improving medicine is more or less distinctive to the European medical tradition. For reasons technical, cultural, religious and personal it was not done in China or India, Mesopotamia, or Pharaonic Egypt.”⁵ The Western view of medicine and henceforth the U.S. understanding of medicine reduces the body into individual human parts and interprets disease as the malfunction of one of the body’s parts.⁶ There is a disregard for broader social contexts influencing health or the mental and emotional components to a person’s well-being. These uniquely physical, or biomedical, and reductionist perceptions of health are inseparable from the U.S. health care system and suggest a bias for individualist instead of community oriented health care services.

Many conflicts arise from the biomedical perspective of health and the notion of viewing well-being solely in terms of an individual’s physical biology. First, biomedicine assumes the fix or cure of an illness is a matter of restoring the broken part to its original function. The solution to an illness is derived from isolating the problem and disregarding external factors that may have led to the particular health outcome. As Paul Starr describes, U.S. “conceptions of disease and responses to it unquestionably show the imprint of our particular [Western] culture.”⁷ Yet, the diversity of the U.S. population, various patient experiences, and the complexity of human health and illness, demand for more culturally competent health care beyond the Western paradigm. Cultural competency refers to the ability of a health care practitioner to respectfully serve different people with different cultures.⁸ The topic of cultural competency will be explored further throughout the analysis of CHW case studies. Implicit in the need for culturally

⁵ Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity*, 8.

⁶ Jacques Roger, “The Mechanistic Conception of Life,” *God and Nature: Historical Essays on the Encounter between Christianity and Science*, 1986, 291.

⁷ Paul Starr, *The Social Transformation of American Medicine*, Basic Books, 1982. pg. 3.

⁸ “Training Curriculum for Community Health Workers” (Washington State Department of Health, August 2015).

competent care, however, is an understanding that U.S. health services disregard broader cultural and environmental factors influencing individual well-being. Apparent already, therefore, is the dissonance between a community-oriented health care such as the CHW model and biomedical assumptions in health.

A second challenge with U.S. health care is that medicine is privatized. Porter writes, “Health became one of the major growth industries in America, encompassing the pharmaceutical industry, manufacturers of sophisticated and costly diagnostic technologies...and medical insurance.”⁹ In other words, the U.S. health system runs like a business, which has resulted in more elaborate and more expensive health care for the well off and the disenfranchisement of populations of people from institutional health care. The patient doctor relationship has also changed as a result of privatizing health care. Patients are more active in their illness experience and view medicine as a consumer good instead of as a public service.¹⁰ The engagement of third party medical websites such as “WebMD” and pharmaceutical ads within the health care market have directly given patients more information about their health conditions and the means to demand treatment for particular illnesses.¹¹ In response, Doctors are more likely to over diagnose or to prescribe unnecessary treatments as a way to address increasing patient demands and the fear of being sued.¹² In this, the privatization of the national health system has lead to underlying assumptions and behaviors evident within the day-to-day operations of the U.S. health care system.

⁹ Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity*, 658.

¹⁰ Peter, Conrad. "Medicalization and Social Control." *Annual review of Sociology* 18, no. 1 (1992): 224.

¹¹ *Ibid.*, 224-225.

¹² *Ibid.*, 228.

A third issue with U.S. health care is that the system perpetuates fairly new hierarchies of power and authority, hierarchies that are rooted within the rise of science.¹³ Sociologist Paul Starr describes the U.S. Health care system as “an elaborate system of specialized knowledge, technical procedures and rules of behavior.”¹⁴ The public respects medical professionals and look to the medical community for advice concerning their health and lifestyle choices. Even among the sciences, medicine occupies a special position of authority and status due to its direct contact with the well-being of people and daily interactions with matters of life and death. In this, doctors are given particular liberties over dictating people’s lives and choices that other careers (such as the food industry or politics) might not have the same authority upon which to act. Medicine is a respected field within the U.S. and the public tends to value its opinion for better and for worse.

Furthermore, historians agree that the U.S. health system is a *fragmented* social structure that has resulted from various, complex, historical processes, culminating in many of the challenges facing health care today. As a collective, these shortcomings of the U.S. health system have contributed to a gap in the distribution of health services such that the poorest people have the highest levels of illness and premature mortality.¹⁵ Observable at all levels of income is the trend that different populations experience persistent and increasing disparities in health status and health services. To demonstrate, in Tacoma, WA health gaps are observed in data concerning life expectancy and where someone lives in addition to data measuring correlations between race and infant mortality. For example, people who live closer to I-5 in south Tacoma have a life expectancy of 60-70yrs. Those living in the north end of Tacoma have an average life

¹³ Starr, *The Social Transformation of American Medicine*, 4.

¹⁴ *Ibid.*, 3.

¹⁵ Michael Marmot et al., “Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health,” *The Lancet* 372, no. 9650 (November 8, 2008): 1661–69.

expectancy of 70-80yrs. There is a 10-year difference in live expectancy depending on where one lives in Tacoma.¹⁶ Similarly, data shows that African Americans have double the infant mortality rate of white community members in Tacoma.¹⁷ These statistics, although localized within Tacoma, WA, demonstrate numerically the health gap and how it manifests in health outcomes.

Health gaps, such as those described in Tacoma, are best interpreted within the framework of social determinants of health (SDH). The phrase SDH was first coined at an international primary health care conference held in Alma Ata at the end of the 1970s. In need of urgent health care reform policies, the term was collectively designed to describe how broader social factors interact with individual health outcomes.¹⁸ Most recently, Phelan et al. describe SDH as the fundamental causes of disease (FCD). These causes are “what put people at risk of risks.”¹⁹ FCD are the broader social factors (SES, job-stress, access to resources etc.) that contribute to an individual’s overall well-being and state of existence. Traditionally, Western medicine has ignored these broader contextual factors and has focused on medical treatments that alleviate illness and disease.²⁰ SDH proponents do not deny that individually based medical interventions are ineffective, but rather as Braveman and Gottlieb describe, “[SDH] indicate that medical care is not the only influence on health and suggests that the effects of medical care may be more limited than commonly thought, particularly in determining who becomes sick or

¹⁶ “2013 Pierce County Community Health Status Assessment” (Tacoma-Pierce Country Health Department, October 2013).

¹⁷ Ibid.

¹⁸ Jacqueline Martinez et al., “Transforming the Delivery of Care in the Post–health Reform Era: What Role Will Community Health Workers Play?,” *American Journal of Public Health* 101, no. 12 (2011): 101.

¹⁹ Jo Phelan, Bruce Link, and Parisa Tehranifar, “Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications,” *Journal of Health & Social Behavior* 51, no. 1: 29.

²⁰ Ibid., 30.

injured in the first place.”²¹ Importantly, national CHW programs implicitly and sometimes explicitly emphasize the notion of SDH and thus shift conceptualizations of disease from the individual to broader environmental and community-based factors.

Furthermore, understanding health gaps in terms of SDH relates more generally to health reform movements concerning health as a human right and the notion of health equity. Just as people have social, religious, political and economic rights, SDH and CHW values unite in holding individuals have a right to health and well-being. I argue that CHWs implicitly redefine health as a human right because CHWs address SDH and indirectly improve community well-being and access to health care. Indeed, CHWs are a critical turning point in the U.S. health system because they considerably broaden national efforts to promote health services for the underserved.

To begin, I will define what a CHW is and contextualize the social, political, and historical factors that allowed for the growth of CHWs within the primary health care sector. Then, I will analyze how CHWs perceive their own roles and responsibilities within the U.S. health system as a means of highlighting the gap within health care services and the influence of SDH on well-being. The second part of this paper will relate CHWs to scholarship by medical anthropologist Paul Farmer and public health scholar Alicia Yamin concerning pathologies of power and the need for national health care reform initiatives that prioritize health as a human right. To conclude, I will reiterate how the concept of a CHW informs current perceptions of well-being and health in terms of SDH and embodies the action needed to shift health as a human right social movements from theory to reality.

²¹ Paula Braveman and Laura Gottlieb, “The Social Determinants of Health: It’s Time to Consider the Causes of the Causes,” *Public Health Reports*, 2014, 20.

WHO ARE CHWs: Historicizing CHWs

CHW have a rich history both nationally and internationally. How CHW tell their history informs us of the values upon which CHW programs were founded. The first recorded occurrences of a community based health worker date back to 17th century Russia during a severe doctor shortage. People known as “feldsheds” emerged from the health system as an outreach worker that targeted rural populations in need of care.²² Similarly, in the People’s Republic of China at the start of the 20th century, barefoot doctors were a “diverse array of village health workers who lived in the community they served, stressed rural rather than urban health care and preventative rather than curative services, and combined Western and traditional medicines.”²³ China’s barefoot doctors responded to the inability of conventional allopathic health services to deliver basic health care.²⁴ As awareness for the barefoot doctors program spread, a number of countries began to experiment with the village health worker concept.²⁵ The Spanish equivalent to CHW, *Promotores*, “became a powerful force in Latin America in the 1950s, when labor rights and liberation theology—a Catholic dissident movement that sought to empower the poor against their oppressors.”²⁶ The history of CHWs internationally suggests that CHWs have continually served the underrepresented and marginalized patients in their role as community health advocate and care giver.

²² Leda M. Pérez and Jacqueline Martinez, “Community Health Workers: Social Justice and Policy Advocates for Community Health and Well-Being,” *American Journal of Public Health* 98, no. 1 (2008): 12.

²³ Marcos Cueto, “The Origins of Primary Health Care and Selective Primary Health Care,” *American Journal of Public Health* 94, no. 11 (November 2004): 1865.

²⁴ Anne Liu et al., “Community Health Workers in Global Health: Scale and Scalability,” *Mount Sinai Journal of Medicine* 78, no. 3 (June 5, 2011): 5, doi:10.1002/msj.20260.

²⁵ Ibid.

²⁶ Pérez and Martinez, “Community Health Workers,” 12.

In the United States, CHWs are first explicitly noticed as a result of Lyndon B. Johnson's transformative plan called "The Great Society."²⁷ As part of The Great Society's new careers program, the government created and promoted community health work jobs as entry-level positions for career development. In the early 1960s, the federal government began to formally support community health work programs through the Federal Migrant Health Act of 1962.²⁸ Likewise, the Great Society's Economic Opportunity Act of 1964 and the Indian Health Services Act of 1968 led to the rapid growth of CHW models across the U.S. Many of these first attempts at CHW models, however, failed in the 1980s largely due to their lack of Federal support throughout the Reagan Era. The economic recession in accordance with poor initial planning, problems of sustainability, difficulties maintaining quality, and the lack of a formal structure within the health system led to the sudden decrease of CHW programs.²⁹ But, according to CHW proponents, most recently "the Affordable Care Act has provided unprecedented opportunities for CHWs to serve more formally as integral participants in fixing a fragmented health care system that threatens not only this country's solvency but also the well-being of its citizens."³⁰ The law authorizes funding from Center for Disease Control for CHWs to help promote positive health behaviors and outcomes in medically underserved communities.³¹ Additionally, "The U.S. Department of Labor recommended the creation of a Standard Occupational Classification for community health workers," which was subsequently included in a provision of the 2010 landmark national health reform law.³² These federal health policies indicate the prioritization

²⁷ Pérez and Martinez, "Community Health Workers," 13.

²⁸ *Ibid.*, 12.

²⁹ Martinez et al., "Transforming the Delivery of Care in the Post-health Reform Era," 6.

³⁰ *Ibid.*, 1.

³¹ *Ibid.*

³² E. L. Rosenthal et al., "Community Health Workers: Part Of The Solution," *Health Affairs* 29, no. 7 (July 1, 2010): 1338, doi:10.1377/hlthaff.2010.0081.

and growing importance of CHWs in achieving health care reform for the underserved within the U.S.

In general, today the term CHW serves as an umbrella word for individuals within the health system that connect underserved communities to their local health center. Perez and Martinez describe CHWs as “the integral link that connects disenfranchised and medically underserved populations to the health and social service systems intended to serve them.”³³ CHW are also called promotoras, natural helpers, doulas, lay health advisers, and frontline workers depending on the location in which they work. Despite the variations in name, all of these positions aim to increase access to care and provide health services ranging from health education and immunization to complex clinical procedures in remote areas where they are often the only source of health care.³⁴

Training for CHWs varies from state to state. In WA, to become a CHW an individual must participate in an 8-week certification process funded and run by the WA state public health department. Although the training is free, CHW programs are a full time commitment that requires both online and in person classroom sessions. CHWs can have a bachelor’s degree prior to completion of the training. This allows for an expedited certification process. Bachelor’s degrees, however, are not required for admission into the WA state CHW program.³⁵

There are two types of CHWs within the U.S. Both aim to allocate care that is beneficial and accessible to the community in which they work. First, there are CHWs that are hired from outside of a community to work on behalf of those within the community. This type of CHW is very common in the U.S. because the communities that CHWs serve are predominately low-

³³ Pérez and Martinez, “Community Health Workers,” 11.

³⁴ Ibid.

³⁵ “Training Curriculum for Community Health Workers.”

income areas where people are not often in a position to receive the training needed for service as a CHW. In this, the CHW works on behalf of a community instead of developing a program that mobilizes community members to work for their own community. Public health scholars argue that these CHWs *must* build trust and close relationships with the people in their communities to *effectively* help them navigate the complexities of the health care system influencing their lives. Otherwise, the CHWs are at risk of emulating paternalistic health reform efforts that belittle the community.³⁶ The second type of CHW is from the community they serve. Public health scholars agree that these CHWs are particularly well placed to alleviate issues of cultural competency and are inevitably invested in the well-being of their communities because they are members of the care district in which they work.³⁷ Rosental et al. go so far as to argue that “Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, [and] should be supported by the health system.”³⁸ Either way, the expectation for both types of CHWs is to develop peer-to-peer connections and trust with the patients, by demonstrating health professionals are friends from within the community as opposed to outsiders ignorant of the challenges within their respective care district.³⁹

CHW CASE STUDIES

Specific examples of CHW interventions filling gaps within health care can be seen in the states of Minnesota, Massachusetts, and Washington amongst the findings of a national CHW

³⁶ Pérez and Martinez, “Community Health Workers,” 11.

³⁷ Rosenthal et al., “Community Health Workers,” 1340.

³⁸ *Ibid.*, 3.

³⁹ Uta Lehmann and David Sanders, “Community Health Workers: What Do We Know About Them? The State of the Evidence on Programmes, Activities, Costs and Impact on Health Outcomes of Using Community Health Workers,” *World Health Organization*, no. Evidence and Information for Policy (January 2007): 1338.

survey conducted by the Health Resources and Services Administration Bureau of Primary Health Care (BPHC). The analysis of CHW case studies within the U.S. demonstrates the wide range of personal, social, economic, and environmental factors that influence health status. These health determinants suggest that gaps in health services are not necessarily about the shortage of biomedical treatments for disease/illness or an emphasis on the human body. Rather, gaps in health care are formed from a lack of recognition of – and thus intervention in -- the broader social factors influencing health and well-being.

In the BPHC study, seven nationwide CHW programs were surveyed for their overall effectiveness and contributions to the communities they serve. The study was one of the first to evaluate the comprehensive influence of CHWs in various locations across the country at the beginning of the 21st century.⁴⁰ The data incorporated in the survey is drawn from conversations with health center's executive directors, chief financial officers, CHW program administrators, CHW supervisors, CHWs and client-based focus groups. The qualitative data drawn from the survey was interpreted to determine the outcomes of CHWs on patients' access to services, proper use of services, and patient knowledge and behavior.⁴¹

Evaluating the demographics of CHWs incorporated within the survey highlights the population most directly influenced by CHW programs on a daily basis. As explored in the previous section, a popular CHW model is training people from within an underserved community to work as a CHW for their own community.⁴² Likewise, the BPHC study reports

⁴⁰ Health Care for the Homeless, CA; Brownsville Community Health Center, TX; Logan Height's Family Health Center, CA; Northwest Michigan Health Services, MI; Regional Medical Center at Lubec, ME; Syracuse Community Health Center, NY; West Alabama Health Services, AL ("Impact of Community Health Workers on Access, Use of Services and Patient Knowledge and Behavior," 11-15.)

⁴¹ United States Health Resources and Services Administration Bureau of Primary Health Care, "Impact of Community Health Workers on Access, Use of Services and Patient Knowledge and Behavior," *Health Resources and Services Administration Bureau of Primary Health Care*, no. 1 (January 2, 1999): 2.

⁴² *Ibid.*, 4.

that most CHWs have some level of *shared experience* with the community in which they work. For example, if a CHW was working with homeless populations, then it was likely that the CHW had also been homeless in the past.⁴³ Understanding whom CHW programs employ thus suggests who is left out in the current health care model. The study reports that the majority of CHWs are female. Despite attempts to recruit both men and women for the position, the study implies that women are more often unemployed and have time to commit to a CHW training program. Additionally, because women are often seen as natural caregivers due to gender norms concerning the role of women in society, community members tend to believe that community health work is more fit for women.⁴⁴ The second characteristic of CHWs the study highlights is that many CHW employed in the U.S. do not have high school degrees and lack significant prior work experiences. These two observations concerning CHWs as a whole suggest that uneducated women are predominately underserved by community health services since this is the main demographic of people working as CHWs in the U.S. In the BPHC study, there are no direct correlations drawn between race and CHWs.⁴⁵ Additional studies, however, suggest it is likely that many CHWs also reflect the racial composition of the communities they serve.⁴⁶ Thus, recognizing whom CHW programs employ indirectly highlights who is left out in the current health care model and who is in need of better health care.

Despite the assumptions drawn above about the demographics of CHWs, The MN Community Health Worker Alliance demonstrates the variability of CHW profiles amidst programs that draw CHWs from outside of a community to work. Joan Cleary of the Minnesota

⁴³ United States Health Resources and Services Administration Bureau of Primary Health Care, "Impact of Community Health Workers on Access, Use of Services and Patient Knowledge and Behavior," *Health Resources and Services Administration Bureau of Primary Health Care*, no. 1 (January 2, 1999): 4.

⁴⁴ *Ibid.*, 4–5.

⁴⁵ *Ibid.*

⁴⁶ Goodwin and Tobler, "Community Health Workers," 3.

Community Health Worker Alliance blog notes that CHWs bring young people into the field of health care. The CHW program encourages growth in the health care workforce and introduces the job as a position for young professionals looking for careers in medicine.⁴⁷ The MN CHW alliance emphasize CHW jobs as entry level positions within the field of public health and likewise as support systems for more established positions in the field (i.e. physicians & nurses). The approach to hire individuals to work on behalf of an underserved community is not the same as the CHW model highlighted in the BPHC study that employs people from the community in which they serve. Although the BPHC study already draws from multiple CHW programs across the country, I supplement the survey results with additional CHW sources from Minnesota, Massachusetts and Washington to account for the variability of CHW profiles from one state to the next.

To begin, according to the BPHC study one benefit of CHWs is that they strengthen relationships between community members and health providers. This influence suggests that health care providers prior to CHW interventions were not effectively connected to the communities where they resided. It is possible that this lack of connection correlates with cultural barriers between doctors and patients on a more personal level. Likewise, the lack of connection could refer to physical distance and the space between the community health center and the community it serves.⁴⁸

CHWs from the Somalian health board in Tukwila, WA and the MN Health Alliance demonstrate how physical distance influences the connection between community health centers and the people they serve. According to a WA State CHW in Tukwila, WA, the nearest

⁴⁷ “CHW: MN Health Alliance,” accessed November 13, 2016, <http://mnchwalliance.org/>.

⁴⁸ United States Health Resources and Services Administration Bureau of Primary Health Care, “Impact of Community Health Workers on Access, Use of Services and Patient Knowledge and Behavior,” 5–10.

community health center is five miles away in any direction.⁴⁹ Many families that need CHW interventions are physically isolated from the community health centers that could meet their health care needs.⁵⁰ Similarly, The MN CHW Alliance reports that the key role CHWs play in their organization is the “bridge between the community and medical services and resources.”⁵¹ The organization’s explanation of the CHW role implies that communities are not adequately connected to the medical resources available within the state. In other words, MN community health centers are not necessarily short on health resources as much as they lack a means of communicating and distributing health resources to the community. CHWs recognize that communities need connections with their community health centers. This shortcoming of the U.S health system does not denounce the resources available at the health center. Instead, it suggests that CHWs highlight the inability to effectively distribute health resources to the relevant populations within a community. Those that need health care the most are unable to access care as a result of the distance between health centers and their local communities.

Second, the BPHC study determined that CHWs increase overall community participation within the health care centers.⁵² The Somalian Health Board, Massachusetts Housing Project, and MN CHW Alliance demonstrate the influence of CHWs in improving community participation. According to the Somalian health board, the democratic involvement of community members in decision-making processes helped people feel more connected with their primary health centers. The direct involvement of community members in health committees and meetings resulted in greater participation in the local health system and

⁴⁹ Ellen Erving, WA State Community Health Worker Experience, Phone Interview, September 23, 2016.

⁵⁰ “Somalian Health Board,” www.somalihealthboard.org, accessed November 9, 2016, <http://www.somalihealthboard.org/>.

⁵¹ “CHW: MN Health Alliance,” accessed November 10, 2016, <http://mnchwalliance.org/>.

⁵² United States Health Resources and Services Administration Bureau of Primary Health Care, “Impact of Community Health Workers on Access, Use of Services and Patient Knowledge and Behavior,” 10.

increased health advocacy in day-to-day endeavors.⁵³ In Massachusetts, after the establishment of a CHW program in Columbia Point, the proportion of community members who had received a general health examination increased substantially from 17 to 59 percent.⁵⁴ There are many possible explanations for the observed increase in community participation. One explanation that the MN CHW Alliance describes is that CHWs are integral members of the primary health care team. CHWs promote health education, improve case management, support full time staff, provide culturally relevant care, and most importantly “create a trusting environment while utilizing the appropriate language for understanding.”⁵⁵ These contributions to the health care team directly relate to the growth of participation within the system. For example, CHWs are able to assist with lower order patient concerns such as vaccinations while full time staff members like physicians and nurses can attend to more urgent health needs. Doctor burnout rates are reported significantly above average compared to other careers in the country. As a result, Doctors and nurses are unable to keep up with the huge demand for health services.⁵⁶ CHWs provide support systems to full time staff and therefore, decrease the caseload of doctors and nurses and increase the number of patients primary health centers are capable of reaching overall.

Another way that CHWs have influenced community participation is through the establishment of peer-to-peer relationships and a trusting environment. Doctors are often

⁵³ “Somalian Health Board,” www.somalihealthboard.org, accessed November 13, 2016, <http://www.somalihealthboard.org/>. 5.

⁵⁴ Seymour S. Bellin and H. Jack Geiger, “The Impact of a Neighborhood Health Center on Patients’ Behavior and Attitudes Relating to Health Care: A Study of a Low Income Housing Project,” *Medical Care* 10, no. 3 (1972): 228.

⁵⁵ “CHW: MN Health Alliance.”

⁵⁶ ER physicians, specifically, have a burnout rate of more than 50%. (“Physician Burnout: It Just Keeps Getting Worse,” *Medscape*, accessed December 10, 2016, <http://www.medscape.com/viewarticle/838437>.)

perceived as “elitist” and tend to view their career as more meaningful than others.⁵⁷ Medical elitism in many communities is viewed as a barrier to health care resources and services because it is the foundation for power-based relationships that negatively impact the health care experience.⁵⁸ CHWs are a more welcoming intervention because they are individuals from the community (or trained to assist a particular community) that can relate and empathize with the community in need. Their peer based interactions have led to increased participation in primary health centers and suggests that primary care center programs and goals were not optimizing community participation prior to the implementation of CHWs.

Additionally, the BPHC study concludes that CHWs provide culturally competent care in primary health systems, which has led to improved participation in community health centers. Cultural competency is described as “a congruent set of behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.”⁵⁹ In WA State, the ideal administration of culturally competent care is achieved through the development of active listening, clear verbal and non-verbal communication skills and empathy.⁶⁰ A CHW from Washington State described how when working with Somalian refugees in Tukwila, WA she often was there to listen to the patient’s concerns and to ensure the patient that their needs were met. Through these conversations, the CHW was able to understand the community member’s intense fear of Western medicine and likewise their fear of vaccination.⁶¹ She described how CHWs worked with the local primary care centers to first recognize the concerns of the patient

⁵⁷ Cueto, “The Origins of Primary Health Care and Selective Primary Health Care,” 1865.

⁵⁸ Starr, *The Social Transformation of American Medicine*, 24.

⁵⁹ “Training Curriculum for Community Health Workers.”

⁶⁰ Ibid.

⁶¹ Erving, WA State Community Health Worker Experience.

and then communicate the importance of vaccinations for their children in particular. This is a delicate process, she explained, because it involves a dialogue that respects where the patient stands and their own cultural values.⁶² Vaccinations in particular are an interesting example because they are a fairly simple biomedical intervention that can be brought directly to communities. Yet, if the communities do not understand the health service or the reason for vaccinations because of their own values and conceptualizations of health, an issue arises of balancing the community needs with the services available from primary care centers. In this way, the CHW mediates between the health center and community to improve community participation in the local health system. Furthermore, CHWs' emphasis on culturally competent care highlights the need for variation in medical services so that it is culturally acceptable. As the health system stands, medical interventions do not necessarily fit together with all cultural norms. This is a relevant and urgent concern in the U.S. because thousands of immigrants and refugees arrive each year and most seek citizenship. The U.S. National health care systems should respond to Americans variety of needs and strive to allocate care that is accessible for the population in need.

The final conclusion that the BPHC report makes is that CHWs have helped to expand existing projects within primary health centers and likewise implement new programs within the community health centers. The study describes how prior to CHW involvement, many primary care centers lacked sufficient human resources needed to implement and expand the outreach of their programs. The growth of new programming with the implementation of CHWs suggests that health centers are able to respond to community needs and adjust programs so that they meet

⁶² Erving, WA State Community Health Worker Experience.

community preferences due to the engagement of CHWs.⁶³ One federal program in particular that has grown since the establishment of CHWs is the “Racial and Ethnic Approaches to Community Health Program ” (REACH). REACH is a national program established in 2014 by the Center for Disease Control (CDC). The national initiative to reduce racial and ethnic health disparities is implemented through the work of CHWs in various local partner organizations. REACH’s utilization of the CHW model allows for national public health initiatives to influence more local settings and to extend to underserved communities in need of health reform and improved health care services.⁶⁴

Another example of the expansion of new primary health programming using CHWs is the expansion of health insurance enrolment through new interventions in the Affordable Care Act (ACA). In Massachusetts, CHWs played a highly visible role by helping more than 200,000 uninsured people enroll in health insurance programs, as mandated by the new ACA.⁶⁵ Likewise, data from Minnesota and Washington suggests that Medicaid programs are increasingly using CHWs to expand the health care safety net to reach underserved populations in their states.⁶⁶ These are strong indications that the implementation of CHWs bolsters both local and national efforts to improve access and services in the national health system.⁶⁷ Their involvement in the administration of national health reform efforts also indicates that many federal health policies are not adequately equipped with the resources needed to ensure success at a local scale.

The analysis of the BPHC study in concert with Minnesota, Massachusetts, and Washington CHW programs demonstrates that primary health services lack adequate distribution

⁶³ United States Health Resources and Services Administration Bureau of Primary Health Care, “Impact of Community Health Workers on Access, Use of Services and Patient Knowledge and Behavior,” 5.

⁶⁴ “States Implementing Community Health Worker Strategies,” *Center for Disease Control*, December 2014, 6.

⁶⁵ Rosenthal et al., “Community Health Workers,” 1340.

⁶⁶ “CHW”; “Training Curriculum for Community Health Workers.”

⁶⁷ Goodwin and Tobler, “Community Health Workers,” 11.

of health resources within the community, accessible health centers and services, strong doctor and patient relationships, culturally competent care, community participation, and the expansion of public health initiatives to meet community-based health needs. These shortcomings within the primary care sector demonstrate how the U.S. patchwork of a health system fails to address community specific health care needs. Likewise, CHW interventions suggest that what communities perceive as “good care” is comprehensive and integrated medical resources because people’s needs are complicated and inseparable from broader social factors. As a result, no one-health service is sufficient to meet community needs.⁶⁸ Instead, CHWs as generalists, or as persons competent in many fields of health care, are able to fulfill multiple gaps within the fragmented system and furthermore define shortcomings in U.S. health care as an inability to address broader social factors influencing well-being.

Another way of summarizing health care shortcomings in terms of CHW contributions to care is through the notion of health equity: *different* people are in *different* circumstances and need *different* services to reach a state of well-being. CHWs roles and responsibilities demonstrate that the health system fails to address health inequities, or the *difference* in community specific health care needs. Their role defines the gap within health care as the intersectionality of social factors and attempts to engage with alternative methods of allocating care through close community engagement. Patching gaps within the health system will not necessarily arise from the development of a new drug or medical treatment. Instead, identifying the gap in health care as lack of health services for addressing Social Determinants of Health [SDH] is a demand for policy change that defines well-being beyond the body and as an extension of broader social factors.

⁶⁸ United States Health Resources and Services Administration Bureau of Primary Health Care, “Impact of Community Health Workers on Access, Use of Services and Patient Knowledge and Behavior,” 10.

KEY FINDINGS

To one extent, the CHW can connect people to health resources no matter if they are from the community they serve or not. The challenge with their role as bridge between the medical resource and community is that the CHW working on behalf of a community might not understand the health needs of the community as well as a CHW that is from the community they serve. To another extent, CHWs are advocates who can attest to the day-to-day realities of marginalization and how health inequities must be remedied as a member of the community they serve. Once again, however, the CHW working on behalf of a community has the privilege of leaving and entering the community whenever they choose as opposed to being an advocate that directly experiences the health conditions of the community. For a CHW that lives outside of their care district, an assumed level of privilege is present that comes with the CHW's ability to leave and enter the community when they choose. In this, CHWs must continuously recognize the place of privilege they hold within a community as the connection between community members and health resources such that they are not *perpetuating* inequalities within the health system but instead *addressing* inequalities. .

Proponents of CHWs argue that, although the central role of the CHW is helping patients get access to health care or social services, “they do more than merely link individuals to a doctor’s office.”⁶⁹ Many public health scholars point out that, because of CHW’s insights on the needs of their communities, CHWs are in a position “to inform policy based in reality.”⁷⁰ As members of community based delivery teams, CHWs spend time getting to know the health needs of their community and build individual and community capacity for health care through

⁶⁹ Pérez and Martinez, “Community Health Workers,” 11.

⁷⁰ Ibid.

increasing their general health knowledge and self-sufficiency within the health system. These community-based relationships, rather than clinical expertise, contribute to the workers' ability to address various gaps within the health care system and to contribute to national efforts for health care reform.⁷¹ Likewise, CHW have contributed significantly to the process of promoting community participation that can inspire government programs. One example of community participation leading to governmental response was in the Brazilian health care reform movement. Perry et al. writes about the growth of CHWs as a movement in Brazil that incorporated two clear agendas. First, there was "a service oriented agenda of extension of preventative and curative services within the existing health system."⁷² The second component of the agenda "was concerned with the engagement of communities in the process of taking responsibility for their health and addressing the environmental, social, and cultural factors that produce ill health, including inequity and deep poverty."⁷³ These health movements in Brazil led to the implementation of a new universal health system, which intended to address the needs of the people.⁷⁴ CHW proponents point out how CHWs have not only increased the coverage of health care amongst community members, but also have worked to promote a sense of activism and engagement within communities as seen within the establishment of a universal health care system in Brazil.

⁷¹ Lehmann and Sanders, "Community Health Workers: What Do We Know About Them? The State of the Evidence on Programmes, Activities, Costs and Impact on Health Outcomes of Using Community Health Workers," 1338–39.

⁷² Henry B. Perry, Rose Zulliger, and Michael M. Rogers, "Community Health Workers in Low-, Middle-, and High-Income Countries: An Overview of Their History, Recent Evolution, and Current Effectiveness," *Annual Review of Public Health* 35, no. 1 (2014): 3, doi:10.1146/annurev-publhealth-032013-182354.

⁷³ Ibid.

⁷⁴ Jairnilson Paim et al., "Health in Brazil 1: The Brazilian Health System: History, Advances, and Challenges," *The Lancet* 377, no. 9779 (May 21, 2011): 1778.

CHWS & HEALTH AS A HUMAN RIGHT

I put CHWs in conversation with public health scholars writing about health as a human right because I recognize that there are similarities between the services CHWs provide as outlined above and the health outcomes human rights activists strive to achieve in the U.S. Paul Farmer and Alicia Yamin provide the main theoretical foundations for health as human right arguments in the field of public health. Although they do not explicitly mention the work of CHWs, I will suggest how CHWs embody broader themes within health as a human right literature.

To begin, there are various trends in the way people talk about human rights. Since the presidency of Thomas Jefferson, U.S. health care has been closely linked to the promotion of human rights. At the start of the seventeenth century, Jefferson expressed “confidence that the right to life, liberty and the pursuit of happiness would foster a healthy nation.”⁷⁵ In essence, striving to fulfill the constitution’s declared human rights would indirectly improve community well-being. Yet, throughout the growth of the U.S. democratic institution, health received minimal support from the federal government and instead philanthropists and businessmen addressed health care as smaller local initiatives.⁷⁶ The U.S. as a large and new nation continually worked to balance the role of the federal government with personal liberties. As such, many believed keeping government involvement to a minimum was the key to maintaining individualism and therefore a healthy population.⁷⁷ Consequently, the U.S. health system has developed into a patchwork of many smaller health initiatives led by the states instead of a universalized federal health system. Although Jefferson and the history of human rights come

⁷⁵ Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity*, n.d., 405.

⁷⁶ *Ibid.*, 417.

⁷⁷ *Ibid.*

from a different historical context, the notion of health as a human right is not a recent development in health care reform movements

Most recently, a social model for health as a human right was revived in 1978 at the Alma Ata International Conference on Primary Health Care.⁷⁸ The conference initiated the Health for All movement, which reasserted the need to strengthen global health equity by addressing social conditions through new intersectional programs. By the late 1990s a growing number of countries embraced the concept of health equity and SDHs as explicit policy concerns.⁷⁹ Despite these shifts in international health agendas, the U.S. has been slow to adopt a health system that venerates a health and human rights framework due to more politically conservative views towards health care. Yamin and Farmer's work demonstrate the theoretical benefits of a health and human rights framework and provide context for a political strategy that is otherwise nonexistent within the U.S health system.

Public health scholar Alicia Yamin defines human rights in terms of participation and individual agency. She writes that “a fundamental distinction of a human rights approach to development and policy-making that affects health is that it aims to enable those who are most impacted by poverty, patriarchy, and disease to be active participants in constructing the solutions to their problems.”⁸⁰ Individual agency within the health system allows for people to recognize their rights and can be obtained through the encouragement and promotion of community participation. In other words, if health is a matter of rights, Yamin argues, “it cannot be considered a handout, and the people who receive services are not objects of charity from

⁷⁸ Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity*, n.d., 417.

⁷⁹ Ibid.

⁸⁰ Alicia Ely Yamin, “Suffering and Powerlessness: The Significance of Promoting Participation in Rights-Based Approaches to Health,” *Health and Human Rights* 11, no. 1 (2009): 6, doi:10.2307/40285214.

their own governments; they are agents who have a role to play in the definition of programs and policies that structure the possibilities for their own well-being.”⁸¹ Additionally, in a rights paradigm, powerlessness and the lack of participation are not simply bad-luck or misfortune, but an injustice. They are the result of systemic oppression and the government’s inability to secure a healthy existence for all.⁸² Yamin explains the fulfillment of human rights in terms of participation and individual agency, drawing attention to the strategies needed to implement a human rights health agenda.

CHWs can be viewed as catalysts of Yamin’s theory through their direct involvement in improving community participation. As demonstrated in the CHW case studies, CHWs demonstrate the influence of active participation in health care and suggest that health equity is possible through *action* on SDH. Yamin’s argument that participation requires empowerment is important because it recognizes the extent to which CHWs are improving the lives of vulnerable and marginalized communities across the U.S. As the BPHC study notes, one of the main contributions CHWs make to the U.S. health care system is by improving overall engagement with primary health centers. In a rights based framework, participation is inextricably related to power.⁸³ Yamin argues that people should feel that they could participate in the systems, which are established to promote their own well-being; CHWs help to make possible this reality.

Medical anthropologist Paul Farmer provides another perspective concerning health as a human right. He argues that that the domain of human rights is far too narrow and that acknowledging basic social and economic rights as seriously as human rights to free speech and

⁸¹ Alicia Ely Yamin, “Suffering and Powerlessness: The Significance of Promoting Participation in Rights-Based Approaches to Health,” 6.

⁸² *Ibid.*, 7.

⁸³ United States Health Resources and Services Administration Bureau of Primary Health Care, “Impact of Community Health Workers on Access, Use of Services and Patient Knowledge and Behavior,” 11.

political freedom would directly improve health care across the country.⁸⁴ Additionally, he argues that deep inconsistencies exist within our health care reform rhetoric as a direct result of the fact that health is not always prioritized as a human right.⁸⁵ “When arguing that health care is a human right,” Farmer explains, “one signs onto a lifetime of work recognizing double standards between the rich and the poor” and the fulfillment of human rights for all.⁸⁶ Thus, health and human rights work is rarely finished because there is such variability regarding what health equity looks like from one context or one person to another. Farmer’s final point is that even if health is not formally recognized as a human right, which is the case in the U.S., the recognition of other social and economic rights should impact the state of an individual’s well-being because health services are inseparable from broader social factors.

CHWs demonstrate the application of Farmer’s theoretical framework for a health as a human right. To one extent, CHW engagement with social, economic, and cultural factors in patient’s lives directly expands human rights beyond health and well-being. This is demonstrated in the SDH diagram below from the Office of Disease Prevention and Health Promotion. Individuals are at the center of broader social, economic, environmental and political interactions within society.

⁸⁴ Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley: University of California Press, 2003), 201.

⁸⁵ Paul Farmer, “Challenging Orthodoxies: The Road Ahead for Health and Human Rights,” *Health and Human Rights Journal* 10, no. 1 (July 9, 2013), <https://www.hhrjournal.org/archives/volume-10-issue-1/>.

⁸⁶ Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, 201–2.

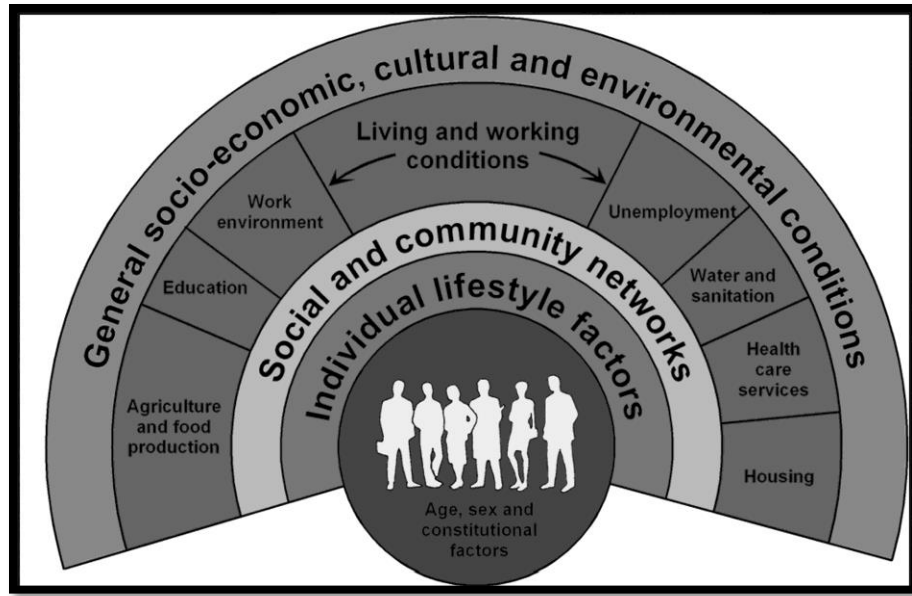


Figure 2: From “Healthy People 2020,” *Office of Disease Prevention and Health Promotion*, Updated December, 2016

To another extent, CHWs outreach in marginalized communities in the U.S. demonstrates the need for more accessible services for the poor and underserved. It is important to note that CHWs as a method of ensuring health as a human right does not need to undermine biomedical interventions of care. CHWs exist within a biomedical health framework in the U.S. and are a means to improve the effectiveness of this particular health paradigm. Similarly, Paul Farmer explains that “If the [biomedical] medical interventions in question were ineffective, or only marginally effective, lack of access to these interventions, though unfair, would be of limited importance. But, biomedicine can at last offer the sick truly revolutionary new therapies.”⁸⁷ For this reason, access to basic biomedical remedies is pertinent in the improvement of overall community well-being and should be viewed as critical as civil rights. Especially when considering the U.S., the “poor have become well-informed enough to reject separate standards of care” and are aware of the services their communities lack in terms of health care and broader

⁸⁷ Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, 203.

social services.⁸⁸ CHWs, therefore, work with underserved communities to improve their access to care and to advocate for their needs such that local health centers respect all human lives as worthy of health as a direct or indirect result of human rights.

CHALLENGES TO HEALTH AS A HUMAN RIGHT

There are two main criticisms against a health as a human rights model. The first is a libertarian critique described by Andrew Bradley. He argues that the main opponents to health and human rights frameworks are those that only believe in the notion of negative rights.⁸⁹ Positive rights require the government to provide a specific service to the people, often via the collection and redistribution of resources. Negative rights such as life, liberty and the pursuit of happiness ask that the government not inhibit or conflict with these established freedoms. When human rights are expanded to include positive rights (i.e. the right to health care) other people's rights are infringed upon by being asked to endure higher taxes to provide a service for the common good.⁹⁰

Nayar and Kapoor explain another criticism of the health as a human right framework through the notion of SDH. Their critique is far more urgent and suggests that it is hard to act on social factors concerning health when people are unaware of them.⁹¹ In other words, there is a lack of knowledge concerning the intersectionality of health care and thus people are not able to respond to relevant social factors influencing health care because they are unaware of the

⁸⁸ Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, 203.

⁸⁹ Andrew Bradley, "Positive Rights, Negative Rights and Health Care," *Journal of Medical Ethics* 36, no. no.12 (2010): 838, doi:<http://www.jstor.org/stable/25764330>.

⁹⁰ *Ibid.*, 839.

⁹¹ K.R. Nayar and Sonali Sahni Kapoor, "Commission on Social Determinants in Health: A Piece Meal Move?," *Indian Journal of Medical Research*, February 2009, 118.

fundamental causes of disease and health in the first place.⁹² Furthermore, Nayar and Kapoor write that there are critical power relations that determine which fundamental causes of health are worth knowing or prioritizing over others. Not only are people ignorant of what SDH are but also, certain SDH are prioritized as a result of the greater systems established.⁹³ Whether one SDH is more important than another is perhaps a subjective topic to discern. With this in mind, Nayar and Kapoor's concern asks how SDH can be shared more publically so that all SDH are viewed as equally important in the allocation of health resources?

To Nayar and Kapoor's concern that SDH are not effectively communicated, I think it is important to consider why SDHs are not a matter of common knowledge. How has our biomedical system influenced the way that people conceptualize disease? Typically, U.S. health care is more oriented toward the individual and ways to cure the physical experience of illness instead of alleviating the causes that led to the illness in the first place. Additionally, I would agree that the influence of SDHs framework is limited. SDHs serve as a strong *indicator* for identifying underserved populations but SDHs are not a tangible solution. Consider, for example, low socioeconomic status as a social determinant of health. Targeting areas of low socioeconomic status across the country with health reform agendas will not always be successful since low socioeconomic communities correlate with resource deficits. For example, a new clinic in a low socioeconomic community would not influence the socioeconomic status of the people in the community. Instead, it temporarily targets a community in need of health services until resources are depleted due to the inherent reality that low socioeconomic neighborhoods lack the resources needed to maintain a health clinic in the first place. CHWs as

⁹² K.R. Nayar and Sonali Sahni Kapoor, "Commission on Social Determinants in Health: A Piece Meal Move?," *Indian Journal of Medical Research*, February 2009, 118.

⁹³ *Ibid.*, 119.

an extension on a community health center can help to manage broader SDH through preventative outreach and program expansion so that local health resources are not depleted instantaneously.

Another way to consider Nayar's and Kapoor's critique is that the SDH framework makes issues within health care too complex to understand. The complexity of the problem contributes to people's inability to understand the problem in the first place. Complexity, in this way, is a double-edged sword that has the potential to strengthen perspectives of health reform and to confuse the public. Both critiques against CHWs challenge the notion of positive rights and the promotion of SDH rhetoric. Although it is important to continue expanding on SDHs to improve access to health resources, there are limits to the SDH framework, which results most directly from the fact that SDH are not a cure for disease but an effective indicator of who gets sick and why.

CONCLUSION

The analysis of the place for CHWs within the U.S. health care system demonstrates shortcomings in the current biomedical approach to health care. CHWs define these gaps within U.S. health care as an inability to recognize the social determinants of health, including socioeconomic status, education, housing, gender, race, ability etc. Through CHW's acknowledgement of SDHs, the U.S. health system becomes more accessible to underserved populations. More generally, CHWs fit within health agendas concerning the social construction of well-being and promotion of human rights. Through the synthesis of scholars such as Farmer and Yamin, CHWs are seen as the embodiment of health as a human right health policy agenda because of their direct engagement with the fundamental causes of health disparities and social

factors influencing the patient's experience. Farmer writes, "an irony of this global era is that while public health has increasingly sacrificed equity for efficiency, the poor have become well-informed enough to reject separate standards of care."⁹⁴ He argues, "We must decide how health professionals (from providers to researchers) might best make common cause with the destitute sick, whose rights are violated daily."⁹⁵ In this, perhaps the biggest shortcoming of biomedical interventions are their inaccessibility for underserved communities across the country and their presence as a direct barrier to health as a right.

Additionally, the assertion that health care must be viewed as a right for all people directly relates to the incorporation of CHW models as methods for improving the exchange of medical services to the public. Once well-being is seen as a result of broader social factors, origins of disease are no longer isolated entities within the body. Patients instead are placed within a broader social and environmental context beyond the services provided by community health centers and specialized hospitals. These conclusions suggest highly trained medical professionals are not the only individuals contributing to the promotion of health and well-being. CHWs expand upon the notion of community responsibility by holding larger systems accountable for influencing community health. In other words, since health is inseparable from greater social factors, CHWs demonstrate how public health agendas need to shift away from solutions that are grounded solely within the health system (i.e. building more clinics for underserved areas). Instead, health reform initiatives should look to programs typically beyond our perceptions of health care, which account for broader social factors interacting with the U.S. health system.

⁹⁴ Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, 218.

⁹⁵ *Ibid.*, 228.

A CHW from the state of Washington said that, “the U.S. health care system is broken and communities are not adequately receiving the medical care that they need.”⁹⁶ Understanding the impact of CHW within global health systems draws attention to methods currently being administered to help bridge the gaps within health care services. CHW programs have the potential to inform U.S. public health policy and to initiate meaningful change from the ground up. Although it is well known that health care is in need of reform, many lack an understanding of the ways in which the health system can and perhaps should be reformed. Through the analysis of CHWs, awareness of the social, political, environmental, and socioeconomic factors that impact the quality of an individual’s well-being is acquired. Once it is understood that health care ideas and norms are intertwined with global economic markets and political endeavors, health reform can be prioritized, as a catalyst for equity and a mechanism for allocating medical services that are accessible for all.

⁹⁶ Erving, WA State Community Health Worker Experience.

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