Henry Ford Hospital Medical Journal

Volume 38 | Number 2 Article 2

6-1990

The National Health Agenda: The Troubling Future of the American People

Reed V. Tuckson

The National Health Agenda: The Troubling Future of the American People

Reed V. Tuckson, MD*

Our ability to prevent disease, to promote health, and to deliver health care to urban Americans in the 1990s is a troublesome concern. It is important that we come together to sound the alarm, to dedicate ourselves to the difficult work at hand, to inspire, enlist, and organize the multiple elements of our total community into this urgent struggle and to think well and hard about the menu of solutions that we must put on the national health agenda, the agenda of the American people.

This issue, the quality of the survival of our countrymen and our countrywomen, should be more important on the national agenda. We have some fundamental contradictions in our great country. Our image of America, as portrayed in our national public relations campaigns, collides violently with reality. For example, while we are and ought to be greatly concerned about issues such as flag burning, each year 60,000 Americans of color die prematurely, in excess of what they would have died if the health status of black, brown, red, and yellow Americans were the same as that of white Americans. Sixty-thousand people who die prematurely is infinitely more important, symbolically as well as realistically, than flag burning. It is troublesome that *this* reality does not cause us to march down the main streets of all of our American cities to protest, to be concerned, and to mobilize to protect life.

While we devote great rhetoric and enormous resources to our ability to fight wars in the sky and under the water to protect our country's future, while we talk about fighting wars in our communities against drugs, we do not, as a national preoccupation, devote significant discussion or, more importantly, significant money to ensure that our babies survive the first year of life. As a result, the infant mortality rates escalate in communities across the country. We now lose 40,000 babies in the first year of life annually in this country.

Urban Americans die in numbers that are just unacceptable. Urban America is more polarized today than ever before. Those who "have" are indeed fortunate. They have health, money, aspirations, dreams, and they desire greater insulation from those who have no money, no education, no jobs, no dreams to inspire them to believe in the possibility of a meaningful future. These people do not have good health; they have disease. They have the combination of social forces that serve as cofactors for more disease. We, as a nation, must either decide that this is unacceptable and make the commitment for change, or we can live with the reality of what is happening. This reality clashes violently with our image of what we say it means to be an American.

Many individuals who are responsible for the health of major urban constituencies throughout this country agree that health is the area where all the social forces converge to express themselves with the greatest clarity and the most import for the individual and for society. Health is the most significant determinant of the quality of life of any community, city, state, nation, even the world. That the infant mortality rate is rising all across this country ought to alarm us, because there is no more eloquent indicator of what is happening in society than whether or not babies survive the first year of life.

The health commissioners of the nation stand at the intersection of all the social forces and keep a scorecard. We record so many deaths from this, so many cases of that, so many incidents of this. When we analyze the scorecard, we become aware that the root cause of most of our problems is not in a place called "health" but in a place called society, in all of its multiple components. Analyzing the urban health problems confronting us in the 1990s requires a fundamental look at the entire structure of our society.

The reality of 60,000 excess premature deaths and the diseases that caused those deaths are important for understanding urban America. While I use these numbers and this example of the health problems affecting black, brown, red, and yellow Americans because it in many ways defines the urban health reality, I realize and appreciate that many of our white friends and neighbors are also poor and are confronted by many of these same challenges. Let me mention that my views and emotions regarding this issue are informed by being the Commissioner of Health for the District of Columbia, a city that is 75% black and brown, and where last year 1,484 of my friends, neighbors, and relatives died before they would have if their health status had

*Former Commissioner of Public Health, Washington, DC. Currently Senior Vice President for Programs, March of Dimes, White Plains, NY.

Address correspondence to Dr. Tuckson, March of Dimes, 1275 Mamaroneck Ave, White Plains, NY 10605.

been the same as for the majority of Americans. These people would have been on the planet today and they are not.

What caused these deaths? We have been dealing with the principal causes of disease and death in urban America for a long time. Almost 80% of the carnage resulted from heart disease, cancer, the triad of homicide, suicide and accidents (violence and trauma), diseases of chemical dependency, whether the chemical be alcohol or other drugs, infant mortality, and diabetes. There is nothing esoteric in this list. Because the human immunodeficiency virus (HIV) disease was still a relatively recent phenomena when these analyses were first conducted, these numbers do not include what is an even more ominous, complicating, and interrelated variable.

What will happen in the 1990s? No matter what we do...no matter what right-minded, good-thinking, caring people do, there will be a disaster in the 1990s. It is inevitable.

What do cardiovascular disease, cancer, homicide, suicide and accidents, chemical dependency, infant mortality, diabetes, and the acquired immunodeficiency syndrome (AIDS) have in common? First, these are diseases that occur as a function of how we behave: the choices we make; the chances we take; our reaction to our environment, to the world around us. Second, these are diseases that are either cured, treated, or prevented by access to basic fundamental health care resources. We, as a nation, already have the ability, the labor force, and the technology to prevent, treat, or cure all of them.

Our dilemma arises out of the collision of two diametrically opposed forces. We have many people who are sick and getting sicker because of their behavioral reactions to an increasingly more challenging environment, and we have a health care system with diminishing resources available to manage a higher burden of diseases. The two are mutually incompatible. What will happen in the 1990s? No matter what we do today, no matter what right-minded, good-thinking, caring people do, there will be a disaster in the 1990s. It is inevitable.

The best we can do is to mitigate the dimensions of that inevitable catastrophe. Why must there be a catastrophe? Because we live in an era that says: I want mine, I want it now, I don't care too much about you; it's me, I want it quick, I want it all, and I'm not going to put any more money into any of this sort of stuff. It is very clear where America is coming from: no more taxes, and no real leadership to mobilize the comprehensive resources necessary to prevent disease or treat it once developed.

The federal government must make some decisions, and it has already made some. During the Reagan years decisions were made resulting in federal block grants service reductions and declining commitment to public health insurance. As support for those health programs that were needed at the state and local level dwindled away and inflation compounds the difficulty, insufficient money is available to keep those programs going. At the state and local levels, tax bases are finite and small. In the District of Columbia, for example, the tax base is limited and will not get bigger. However, there are multiple competing demands for that limited amount of money. The major area of increased budget expenditure in urban America is public safety: more police and more overtime for the police. The more police and the more overtime, the more people we jail, and the more money we spend on prisons. The Health Department, however, gets no additional money, and, in fact, its funds are often taken away to support the criminal justice system.

There are multiple competing demands for the limited, fixed tax base. In Washington, DC, because of a shortage of workers precipitated by financial constraints, car registration now takes four hours. However, in a response to public pressure, those jobs will be filled. Meanwhile, the Health Commission lost 75 workers in the public health clinic system, 80 workers in the alcohol and drug abuse treatment system, and 40 workers in the preventive health system. There was no outcry to replace those employees. Why do cars assume a higher priority than human life?

We, as a nation, don't have the leadership or commitment to make health care a priority. We have a problem with access because we have health care providers who also want all they are due. They want their children to go to Harvard and they want to vacation in Bermuda, so they don't take Medicaid anymore because it doesn't pay enough and their overhead is burdensome. So, even though we have a Medicaid program that is straining to try to grow, physicians don't want to participate because financially it does not support their lifestyles. Moreover, some physicians don't want to see poor patients because of malpractice issues. We are all aware of the difficulty in finding obstetricians. Who will actually care for a pregnant woman in inner-city urban America? Is it any wonder that black babies die twice as often as white babies?

Now, when new money does come to the public health care system, it is mandated for AIDS. Unquestionably, we need a lot of money for AIDS, much more even than allocated, yet while we receive support for AIDS the paradox is that no additional resources are available for the cancer program, the infant mortality program, or the cardiovascular disease and treatment program. Those were killing people—60,000 excess premature deaths—before AIDS became a menace.

You cannot go anywhere in the black community and not be continually confronted by billboards promoting death and disease through cigarettes. ...We smoke more cigarettes. We get more cancer. They make more money. It's cold-blooded in urban America.

In addition to the challenges of the public sector, so must the private sector struggle with its responsibilities to its workers and society. The District of Columbia is a city of 607,000 people, 114,000 of whom have no health insurance. That is typical of urban America. The Washington hospitals last year absorbed $100 million of uncompensated care, exclusive of the subsidy to

the city general hospital. The hospitals did not go out of business, although some of them are struggling and significant changes are inevitable. Employers do not want their insurance premiums to increase further and they are unwilling to underwrite other people's costs. Hard negotiations are occurring every day to avoid such underwriting and to prevent cost-shifting. The federal government made sure to eliminate its participation in that practice.

Given these unpleasant realities, what is important for us now is to limit the number of people who become sick. Much of the sickness in urban America is self-induced. It is behavioral. Why do people too often behave in their own worst self-interest? What is it that causes people not to act for their own best interests? How do we explore these complex issues without blaming the victim or being paternalistic and judgmental?

For me, cigarette smoking is the issue that best illustrates these problems. In the District of Columbia, black residents smoked twice as much as white residents when I became Health Commissioner. Why? Part of the reason is because health is not a priority but a luxury for the stressed and struggling. If your world is orderly, if you have time, and if your life is planned, you can prioritize your life and health can become a priority. If you are not enjoying your stay on the planet, you don't take all the steps necessary to prolong that stay. If you like running the planet, you might want to be around to run it a little longer. Cigarette smoking has something to do with those sorts of issues. It also has to do with the way in which cigarettes are advertised. You cannot go anywhere in the black community in any urban metropolis and not be continually confronted by billboards promoting death and disease through cigarettes. Advertisers promote cigarettes as a method of escape from social reality and a means of identification with the hip, sexy, virile, muscular, dynamic, and "in charge" images associated with our ideas of successful Americans. We have people who pretend all day long that they are the "Essence" woman. *Essence*, "the magazine of the new black woman," is distributed all over urban America. Beautiful women with expensive gowns, looking very cool in Bermuda or on the beach. Don't you want to be that? Don't you want to be like the people on "Entertainment Tonight," "Lifestyles of the Rich and Famous," and "Dynasty"? Are you really going to get to be that in real life? Buy a cigarette and pretend. They even have a brown cigarette for brown women. It's called "More." We smoke *more* cigarettes. We get *more* cancer. They make *more* money. It's cold-blooded in urban America. The leading cause of death for black women from cancer is now lung cancer, not breast cancer. You've come a long way baby. There has not yet been an article in *Essence* magazine to warn women about that.

The manipulations of symbols and imagery are very important. I'm concerned about pregnant women smoking cigarettes. Why would a pregnant woman smoke a cigarette? Because she doesn't have the information? Isn't it right there on the box? Haven't we spent enormous effort in public education? We know what we say, but we do not know what people hear. We don't fully understand how our message is received or what the obstacles are to acting on information in a way that changes behavior. Perhaps those who do not believe in the concept of a meaningful future because of contemporary social reality will not do what we believe will promote well-being. HIV infection is another example. We advise young people that casual sexual liaisons might expose them to a lethal infection. Urban males, however, often do not believe that they will grow up and be in charge of or contribute to the world around them. They don't believe that they will even get hired into a job or that they will ever hire and fire others. Because they have no vision of the future, they fall back on the least common denominator of the human experience. If they can't get a job and be in control, they control people through violence or sex. Sex is a source of personal validation for the urban male, especially the urban male of color. The women they make love to make them feel valuable, worthy, worthwhile, loved, appreciated, and cared about. When we ask them to stop making love, to stop having sex, we have no viable substitute to offer. Health is the place where all the social forces converge. The health message "don't make love" is irrelevant in a social context where people don't feel valued or valuable. We are distributing lots of information and nobody hears. Fault and blame are not the issue. Realities must be confronted.

Some crack-addicted women have babies who suffer tragically. You can predict the learning disabilities and the emotional disorders that will result from the damage done to these children. Imagine what will happen to the school systems of urban America in the next few years when the first group of these children enter school. Inevitably, there will be a disaster.

Crack cocaine and drugs are a problem across the country. How do you tell young people who have no money and no prospects for the possibility of a meaningful future not to sell drugs when they want all the things that Michael Milken and his friends on Wall Street want? Everybody wants the same things. These kids that sell drugs are not any crazier in their stupid, warped aspirations than the rest of this crazy, stupid country. People want the same things everywhere: those who steal money on Wall Street are often respected and yet we want to lock up the kids because they're "crazy." They are who we are. They reflect our values. We provide them with no rite of passage, no way to certify manhood, no sign that they are valuable people. Instead, kids take guns and play Wild, Wild West. The gun becomes a rite of passage.

How do we change a culture that allows us to kill each other, sometimes for just a new suit or a new car? I believe that we have many difficult issues as a society that must be solved before we can approach these more specific problems. A terrible example is the drug crack. Emergency rooms and trauma centers are flooded with victims of the violence related to the entrepreneurial aspects of crack cocaine, but perhaps the greatest threat to society is the addiction of our women. Finally, tragically, there is a drug that women like as much as men. They will sell

their bodies for this drug and risk acquiring sexually transmitted diseases (STDs). The incidence of STDs is increasing dramatically across urban America simply because of women's need to get crack cocaine. Some crack-addicted women have babies, of course, babies who suffer tragically. The infant mortality rates are skyrocketing because of crack cocaine. Every month in the District of Columbia ambulances pick up 20 pregnant women who are so compromised by the effects of crack cocaine that they need emergency services. Many babies who are fortunate enough to have survived are found to have anatomical malformations or speech and hearing deficits. You can predict the learning disabilities and the emotional disorders that will result from the damage done to these children.

We should place health care on the national agenda, from the very top to the very bottom of our country. If we are going to win the health fight, it will only be because our community-based institutions work.

Scientists do not understand the long-term effects on fetuses that develop in an environment of chronic dopamine depletion, the result of chronic crack cocaine use. Very likely they will be a little bit different, children whose synapses are not normal. We may not always understand why. Imagine what will happen to the school systems of urban America in the next few years when the first group of these children enter school. Almost no urban American school system now has sufficient resources and energy. What will they do when these children come, these children who need a range of medical, social, and spiritual help which we, as a country, do not have? Inevitably, there will be disaster in the 1990s.

Faced with this catastrophe, we should place health care on the national agenda, from the very top to the very bottom of our country. The energy and commitment that we have for symbols, such as flag burning, must be devoted to real life issues. If we are going to win the health fight, it will only be because our community-based institutions work. The fight is not won at the Health Commissioner's level but at the level of churches, civic associations, and synagogues. It is won in Boys Clubs and Girls Clubs, fraternities and sororities. It is won at the level of an adult who will adopt a young child who needs somebody. Somehow we must get children off of the street and into a building, where we can transmit the responsible values of the American society. But how do we get to the children? Community-based institutions used to do it, but somehow we have lost them.

Before he became Secretary of Health and Human Services, Dr. Louis Sullivan started a wonderful project called The Black Leadership Initiative on Cancer. This effort brings together church leaders, civic leaders, and businesspersons to mobilize local resources in the fight against cancer. We need to nurture such precious initiatives. Unfortunately, community-based organizations are usually not staffed by people who can draft successful proposals to obtain financial grants. Businesses should be encouraged to donate expertise, such as accountants, lawyers, and writers, to assist such worthwhile small initiatives in competing successfully for financial resources. The success of community organizations is a major opportunity for the future health care system in this country.

We must become motivated as individuals to care about the health of ourselves, our family, and our country. Fifty percent of the sixth graders in Washington, DC, have elevated cholesterol levels. Uninformed, unconcerned, or distracted parents continue to prepare meals rich in fats and cholesterol. These parents are not involved in preserving their own health or that of their children. We have to care about our families and ourselves, at the very least we must care about the children.

We must become more skillful educators and communicators. If we spend money on an advertising campaign, we must evaluate whether or not the message is reaching people. If we advise young women that crack cocaine induces premature labor or that cigarette smoking causes low birth weight, we must be sure that they understand that these are liabilities, not assets. Many women use crack to induce premature labor. Not only is their understanding of the health education message poor, but our understanding of the sociology of those issues is also poor. The people who do understand how to communicate with the urban poor are the advertising agencies. Using their techniques and imagery could have a significant impact on health education.

We need a K–12 comprehensive health curriculum in all of our schools and, specifically, a violence reduction curriculum. Moreover, we can do something about violence in our homes. We must set examples for our children by dealing patiently with everyday adverse situations, such as encounters with aggressive drivers on the freeway. Rather than reacting angrily, we must show children that situations can be resolved with patience and tolerance.

We must become motivated as individuals to care about the health of ourselves, our family, and our country. We must become more skillful educators and communicators. We need a K–12 comprehensive health curriculum in all of our schools and, specifically, a violence reduction curriculum. We have to reorder our priorities... We have to be innovative.

We need universal health insurance; however, this will take time. In the interim: All employers must offer health insurance to their employees. All employees must accept the insurance when offered. The working poor may need a subsidy. We must create uncompensated care risk pools so that hospitals can be compensated. We should extend Medicaid to include those with incomes below 185% of the poverty level. Perhaps we cannot do it as long as we continue to build jails and prisons, but we must expand Medicaid. To do so requires reasonable cost controls which do not sacrifice quality.

We have to reorder our priorities in local health departments. Losing 75 people in ambulatory care clinics, 80 in drug abuse clinics, and 40 in preventive care clinics in Washington, DC, means that we have to change our organizational behavior. We may have to stop answering bureaucratic memos from city council people and others who want us to do medically unimportant things. What are we doing instead? Every Wednesday night, the people in public health leadership positions operate a clinic in the poorest ward in the District. I am one of the doctors, my deputy is the social worker, and my chief nurse is the prenatal care nurse. The person who runs the Office of Child Health deals with pregnancy; the Women, Infant and Children program leader and the Commodities Supplemental Food Program leader distribute food and counsel on nutrition. While we cannot take care of all the people, we can at least do this much.

We have to be innovative. We learned that we have to take our programs to the people when they will not come to us. To reduce infant mortality we operate the maternity outreach mobile (the MOM Van). If pregnant women do not come to the clinic, we take the clinic to them. The van is a brightly colored mobile advertisement operated by a wonderfully empathetic woman who drives it through our city seeking out pregnant women. If they have no doctor, she drives them to the clinic. We also have a MOM Van II which goes to hospitals seeking women substance abusers who have just delivered babies. We enlist them in drug treatment while they are in the hospital and we visit them at home later to be sure they keep appointments.

We want the hospitals in the District of Columbia to "adopt" public health clinics. Hospitals choose a clinic and renovate it as an attractive alternative to hospital emergency medical treatment. Such clinics ease financial burdens which hospitals incur treating the indigent. Furthermore, the program provides the clinics with the resources of a major hospital. The public health sector does not always have clinicians who know how to practice cost-effective quality medicine. It often lacks environmental engineers who know how to move patients through outpatient clinics efficiently. Hospitals with these resources must help public health organizations to expand their limited resources.

It is inevitable that the collision of the forces I've discussed will create a catastrophe in the 1990s. There is no national will to provide the needed resources for avoiding disaster. There is no movement to change the values of this country, to lead our people to act in their best self-interest. We have so much work to do and don't have the luxury of discouragement or lethargy. If we are fortunate, the hard work we do will mitigate the dimensions of the disaster. We have no choice.