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## Future Directions for Urban Health Care

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Seth L. Foldy, MD,§ and David M. Kinzer#

**Mr. Gottlieb:**

As the moderator of this panel, I devised a few questions for the panelists to answer.

1. Progress in resolving the problems of urban health care cannot be achieved unless there is a powerful constituency willing and able to advocate solutions. Who has a stake in these issues? How can we increase the number of people/organizations who have a stake in these issues? What kind of alliances should be developed?

2. Realistically, can we expect to be successful in resolving health care problems if proposals focus only on the poor, only on minority groups, or only on urban centers?

3. Should we concentrate our energies and resources on developing "global" solutions to the problems of urban health care (e.g., across-the-board improvement in financing)? Or should we focus on incremental improvements (e.g., focus on specific health problems, specific subcommunities, or specific segments)? If incrementalism is the preferable course, how can we be sure that each step leads toward a "global" solution rather than simply continuing the current patchwork?

4. How can we achieve better cooperation and coordination among the diverse organizations and interests which currently serve the urban area? Can we develop joint ventures between the private and public sectors? Can we develop joint ventures among organizations of diverse types within the private sector? Are there ways to pool dollars currently available for urban health to support more focused approaches to resolving urban health problems? What steps can be taken to minimize "turf" battles which tend to constrain cooperative action by diverse organizations?

5. In many metropolitan areas there has been significant growth of large horizontally and vertically integrated health systems in recent years. What is or should be the role of such systems in resolving urban health care problems? What steps need to be taken to ensure that such systems do in fact address urban health problems? Can such systems reallocate some of the resources they currently use for inpatient tertiary care to the operation of programs and services designed to meet other needs of the urban population? Should they do so?

6. What are the appropriate roles of "grassroots" community agencies in dealing with the problems of urban health care? What services can or should be provided? What kinds of alliances, if any, should they form to deal with the problems more effectively? What kinds of relationships should such agencies have with the traditional health care establishment?

These are the questions I have put forth. Now we can hear the answers of each panelist.

**Mr. Warden:**

Before this conference began I expected that most of us would try to define the urban health problem in relationship to financing and the number of people who are uninsured and, specifically, how to find a mechanism for insuring them. However, Dr. Tuckson's discussion (see pp. 103-107) clarified the realities of health care in the city. To have any impact on urban health problems we need to understand much better than we do the relationship between the problems in urban society and health. In this century most of the impact on the health status of the population has been a result of public health measures, not money spent on personal health services. I cite this fact not to take away from the role that personal health services play, but to emphasize that as we look at urban programs we should rethink where the resources are going.

We need to think in terms of the health status of the entire population. Most of us who are health care providers are principally preoccupied with the effort to deliver more personal health services, which, unfortunately, solves acute problems but returns patients to the same environment. We must be more concerned with population health status and begin to think about how we can impact it.

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#Mr. Kinzer died April 29, 1990.



Our organization has had some successful initiatives in this regard. We "adopted" three schools and are working closely with some of the students. We are working with one community clinic. However, we must rethink our role as a system and reallocate some resources now being used for less urgent programs. Part of the reallocation can be accomplished by doing things differently than we do them now. We have to take a good, hard look at the population we serve. We must find ways to move a lot of personal care which now burdens the emergency room out into the community and explore means to combine programs of health care delivery with those of prevention and community education. A successful example is our teenage pregnancy program.

In order to "do good" in the city, we also have to do well in the suburbs. One of the strategies that large systems like ours must use is to find ways to convert some of the revenue generated in a suburban setting into resources that can be reallocated to the city. Difficulties arise because our suburban friends are not interested in underwriting urban problems.

Our Michigan legislature is considering a piece of legislation that pertains to the role of systems. In the draft is a clause stating that in order to be licensed and have the privileges of a system (which among other things is more flexibility on certificates of need), that system must be willing to care for a share of the uninsured as well as others who do not have access to health care. All agencies, not just providers, must work together to make that happen.

By holding this conference we have acknowledged an obligation on the part of our organization to do more. We created our Urban Initiative because we believe that we need to think about how we are allocating resources in the urban environment and how we can get a greater return from them. All of us must seek out health care purchasers and have dialogue with them about the issues we have discussed. What this city and most other major metropolitan areas need is for someone to wake up society about urban health issues as it was awakened by the environmentalists. Then we can begin to develop the grassroots organization necessary to get people to make the needed changes.

Businesses in this and every other major metropolitan area around the country have a greater obligation than that of trying to control hospital costs; they also have an obligation to society. While they are stepping up to the issues of health care costs, they also must stand up to the related social problems.

On behalf of the Henry Ford Health System, I pledge our commitment to work to develop coalitions which can address these issues in a broad-based way. We must have realistic expectations, but if we don't start now and do it together, it is not going to happen.

**Dr. Shannon:**

The issues addressed at this conference involve complex health problems such as infant mortality, and the discussions have helped me to focus on programs that have appreciated success in addressing such issues. One such program targeted at the reduction of infant mortality offers health, educational, and social services through a network of community-based organizations. Sponsored by the state of Illinois, this program is now ti-

tled "Families with a Future" and incorporates provider groups as well as community groups interested in the reduction of infant mortality. The groups remain diverse and represent religious, educational, hospital, and other groups which are working together to achieve a reduction in infant mortality. The model is used in both rural and urban Illinois communities that have excessively high infant mortality rates.

This conference has also focused on the type of leadership necessary for medical centers to organize community-based programs. Opportunities for medical centers to cooperate with communities in reducing health risks, health costs, and social costs have also received attention. We have been given evidence of successful models for forming focused networks and other cooperative groups. Differences have been overcome and common goals identified. These successes require interactive processes which often also require time. Questions about the degree of difficulty involved in persons and groups setting aside their agendas to accomplish a common goal are frequently raised. Answers to such questions must center on the interactive nature of such processes, the conditions of exchange, the levels of trust, and an assortment of other variables. In other words, there must be a high level of mutual commitment.

A problem in working with "Families with a Future" was the limited understanding at the community level of infant mortality and its implications. The need for community education about infant mortality also included the need to interpret the impact of the problem on everybody in that community, city, town, or county. Unfortunately, we, as health workers, have not been too successful in making such interpretations. We have not always translated the message so that a broad base of community support is generated. Frequently, health professionals talk to each other rather than to the community. Our inability to include the broader community, those not immediately affected, or those not providing services is often a limiting factor in securing funding or other resources.

In order to move any health agenda forward, the issues must be translated effectively, including the impact of those issues on every citizen. Media opportunities are important in achieving this goal. It has been suggested throughout this conference that we need the competence and the methodologies that advertising agencies have and use.

The reduction of infant mortality as well as responses to any other complex health problem depend upon the support of the general public, the health and medical enterprise, and the various levels of government. It is essential to educate people about the threats to their personal health as well as about the threats to community and societal health. Hence, I am impressed that the Henry Ford Health System is willing to take on leadership in the Detroit community to improve the health experiences of inner-city populations. I am sure that there are other organizations willing to work with them in this endeavor, and when the Henry Ford Health System has finished and tested its model, please share it with Chicago and the world.

**Dr. Foldy:**

Lately I've taken inspiration from two quotes. The first is from Antonio Gramsci: "Pessimism of the intellect, optimism of



the will." A hard look at the multiple dimensions of the urban health crisis, made painfully concrete to me by daily exposure to the suffering of my patients, easily leads to burnout and cynicism. Only a stubborn will to search for solutions and the will to fight for them provides the courage and stamina to carry on.

The second statement is a little more upbeat. It was made by a hospital board member to Dr. James Block after he presented the financial and health care failings of ambulatory clinics at their urban hospital. The trustee said, "I thought the doctors at this hospital were creative people. I would think that if we're going to lose \$150,000 a year, we'd at least do it in a way we're proud of."\*

You don't hear much talk like that these days, and it is my hope that a meeting like this will provide a certain sense of adventure to participants; not recklessness, but the determination to do the right thing, to stay the long road, to reject the quick fix, to be, in short, optimists of the will.

Our moderator has asked some probing questions that are appropriately considered as we set off down the long road. The first three address the need to develop a constituency for improved health services for the poor, the viability of solutions directed solely at underserved populations, and the advisability of global versus incremental improvements. The answers to these questions are interdependent. They point squarely to the need for a national health care plan that ends the segregation of the poor into a separate medical system.

Minority groups and the poor are marginalized not only economically but also politically. How can we mobilize a political consensus to provide needed services? Faced with the failure of expensive and ineffective band-aid solutions to America's social problems, the federal government has elected to wash its hands of the responsibility for social policy. This has had two major effects. First, there has been a drastic reduction in the taxation of the rich. Second, the costs of our nation's social failings have been displaced onto municipalities and states; those with the highest proportions of the poor have both the greatest need and the least available resources. Since the poor have been segregated into a separate Medicaid payment system, states are able to contain the financial costs of the system fairly arbitrarily. In the end, the poor absorb the *true* costs in needless suffering in central city ghettos, where they are concealed from polite society. The combined effect has been to redistribute the costs of unnecessary illness to those who can least afford them—the poor, the sick, and the underemployed—while divorcing these populations from more powerful political constituencies.

We have heard at this meeting several compelling reasons for a unified, tax-based payment system for medical care: reduced complexity and regulation, lower administrative costs, improved stability of health care funding, and improved access to care (see Professor Berki's presentation, pp. 119-122). However, the most profound effect of a national health system based on either a flat rate or progressive tax is that every American, from Donald Trump to Mrs. Hernandez down the street, has a similar interest and investment in a health care system that

works for *all* people. Failures of the health care system that perpetuate needless morbidity would hit the pocketbooks of both. President Reagan's pathetically unheeded call for increased private charity to offset tax reductions has brought home the reality that only a cold, hard cash interest in the health of all will create a national constituency for health care for the poor. When Donald Trump bangs the table demanding effective health outcomes for the central city because the acquired immunodeficiency syndrome (AIDS) and trauma and premature births are costing him money, I believe he will find some willing listeners.†

Critics argue that we cannot afford a national health system. Let me first point out, although health care executives may not want to hear it, that a single payer does have much greater leverage to control medical care costs. This includes costs we hear little about, such as the extraordinary profit margins of multinational pharmaceutical companies. For a moment let's take a different tack. Who in this audience could find a use for \$241 billion? That's what the Department of Energy proposes to spend on the nuclear weapons program over the next ten years. Or let me offer you \$4.5 billion which was used for the Stealth bomber in 1989 alone. The state of Michigan will send \$11.5 billion to the military budget in 1989. True, it helps keep America strong: first in the world in military spending, first in the number of nuclear weapons, and first in the number of global military bases. We are also first in narcotic addiction, first in handgun homicides, seventh in spending on public education, 18th in reducing infant mortality, and 22nd in physician-to-population ratio.

Would a national health system, and the capital transfers it might imply, be politically viable? It turns out that the American public is neither heartless nor stupid. A bulletin reporting a 1989 Gallup poll conducted for the Federation of American Health Systems sounds like a broadside from the 1960s. Its headlines read: "Cut defense spending, not health programs" and "Improve health care, even with more taxes." Pessimism of the intellect tells us we must overcome the opposition of powerful interests; optimism of the will demands that we make our democracy do its job. This time around, we must be sure not to segregate the urban poor into a parallel system that allows us to forget they are there. Otherwise we'll be asking the same questions again in another 25 years.

Mr. Gottlieb then asks three further questions as to how we may improve the coordination of the public sector with the private sector and the coordination of large health systems with the grassroots. Early in the decade, Fitzhugh Mullen‡ proposed that we seriously adopt the concept of community-oriented primary care as "an agenda for the 1980s." Perhaps we can finally place it on the agenda for the 1990s. The model calls for health providers, lay citizens, and public health workers to focus together on the epidemiology of morbidity in a given community. Together, they establish priorities for action based on the social and medical costs of prevalent health problems, the perceived willingness of the community to address each problem, and the tools avail-

\*Block JA. Hospital innovations in the community: Ambulatory care. Bull NY Acad Med 1979;55:104-11.

†Author's note: This was presented before Mr. Trump's near-bankruptcy; please insert the billionaire of your choice.

‡Mullen F. Sounding board: Community-oriented primary care: An agenda for the '80s (Editorial). N Engl J Med 1982;307:1076-8.



able for combat. They design health programs that reach out from primary care providers in the community and then regularly assess the success and failure of their efforts.

We know that bringing groups together to accomplish these goals is no small matter. It takes financial support, analytical capabilities, and a determination to work together. It requires that health care managers and providers listen to the language of the community (which may not be English) and that "medicalese" and "administratese" be translated as well. The building blocks are all in place: the struggling community-based providers of primary care, powerful health systems seeking a way of making their mission concrete, academics looking for ladders out of the Ivory Tower, and community groups looking for a responsive ear.

Contrast this approach with our grant-driven appetite for the "disease of the month" (last year low birth weight, this year AIDS) and our obsession with health promotion programs that are more a function of the hospital's marketing department than true public health outreach. Cholesterol levels are screened in health fairs; teenagers are bombarded with television health propaganda; elders are whisked off to lunch at the local hospital. But at the end of the day our patients are no better integrated into a good primary care health care system than before.

To generate ideas is easy, but to bring them about is difficult. It has been a novel pleasure for me to meet here with hospital executives who say they are ready to invest money, time, and staff to tackle the urban health crisis. How can we guarantee that the investment will pay off? We cannot. How can we guarantee that it will fail? That is easier: More band-aids. Continued segregation of the poor. Well-meaning but arrogant and ethnocentric programs that fail to listen to the communities they were designed to serve. And finally, competing with or excluding our colleagues who are already struggling to survive in community health centers and other ambulatory practices. In this day of diminishing expectations, perhaps it is time for us to say, "If we're going to fail, at least let us do it in a way we can be proud of."

**Mr. Gottlieb:**

Mr. Kinzer, would you like to add anything?

**Mr. Kinzer:**

I would like to ask you a question, Sy. All the questions you have put forth relate to working together, coalition building, cooperation between power groups. You are the president of an organization that I think is a coalition. As you have been in charge of the organization for 19 years, I would appreciate hearing your views on what we need to do to make these coalitions effective.

**Mr. Gottlieb:**

The Greater Detroit Area Health Council is the largest health care coalition in the United States, the only one that includes business corporations, labor unions, hospitals, medical societies, insurance carriers, health maintenance organizations, public agencies, and a few consumer groups. We do two things. One is to create forums with all the parties at the table to identify the issues and identify ways to resolve the issues.

Three years ago, a task force of our organization developed a plan for financing health care for the uninsured. A key feature of that plan was to find a way to create a larger stake in the outcome of this issue for all of the concerned principals: major purchasers, all hospitals, all physicians, all insurance carriers. We tried to identify what their roles ought to be and how we could increase their financial stake in the outcome. We've been working for acceptance of the plan ever since.

Our work led to the formation, at our request, of the Governor's Task Force on Access, giving the issue more visibility. Some of our members, including myself, have been active with that task force and one of our members is a cochair.

Our second direction is designed to bring to the awareness of all involved the real nature of health care issues. Accept two principles: First, everybody operates essentially in his own self-interest. The job of our coalition organization is to enlighten the self-interest of member groups. To struggle against individual self-interest in constant confrontation is a useless exercise. One has to find a way to enlighten that self-interest. Second, because everyone is operating in their own self-interest, you have to find ways "to hold their feet to the fire." You must push them, challenge them, and make sure that they never lose sight of the key issue they face. We look for targets of opportunity to make sure our members face these issues. We do these things without the protection of job security.

**Mr. Kinzer:**

I want to add a couple of points because I've been involved in coalitions, too. At some point a coalition has to have an agreement to agree. You reach a point on some of these issues at which everybody says, "We have to do something." "What are you willing to give to get?" This is better done privately. In public coalitions everybody has to stand up and perform for their members and very little happens. Private discussions result in better proposals.

A good technique for building coalitions is to exclude people; to be very exclusive makes everybody want to come in. Maybe this is the time to dismiss everybody, to decide who should be excluded for awhile and to establish conditions for participation.

**Mr. Warden:**

I'd like to comment about the Committee on Affordable Health Care in Seattle. This coalition was instrumental in getting legislation passed and keeping the uninsured issue under consideration. The two factors that contributed to the success of that coalition were a commitment to an idea and a highly focused agenda. After about the first three meetings of the group, we concluded that we couldn't solve all the problems in the world and that we had to set priorities. Our priority was coverage for the working poor in the state.

Another factor made the coalition work: it was not a coalition of representatives of organizations, but a group of individuals who felt they could make something happen. Some of us disagreed every time we got together, but we knew that the right people were sitting around the table. One of the mistakes that we make in health care, because we're basically a participative kind



of people, is that we're too willing to be democratic. By doing so we often weaken the outcome.

**Audience Question:**

Mr. Gottlieb, in terms of the Michigan experience, would you explain incrementalism as an approach to the kinds of overwhelming problems we have in the health care system?

**Mr. Gottlieb:**

The Governor's Task Force on Access to Health Care was polarized into two major groups. One group believed that we ought to recommend a major change in the financing of health care in order to assure access. That group pushed toward either mandated business coverage or a universal health plan. The views of this group were based on the theory that the problem was large, and that if you tried to help only the poor and the minority community and the big city, then the rest of the state would rise up to fight. Therefore, to increase the chances that you could get something done that was useful, you may as well try to do something for everybody. The other group believed that we would not be able to get such plans through the legislature. They said, "The legislature doesn't have any money. They're too busy with the Corrections Department right now to pay any attention to this. If we could get \$500,000 more to spend in one county, to take care of 2,423 people, we ought to settle for that. We should not recommend any more than we can actually get." Unfortunately, that kind of thinking is commonplace in this country. The question isn't which approach is best, but which is more productive and effective in the long run. I was terribly disappointed in the work of the Governor's Task Force.

**Mr. Kinzer:**

Was this because the private sector people on the commission failed to persuade government to go along?

**Mr. Gottlieb:**

No, it had nothing to do with what was going on within the task force; it had to do with what was going on all around us. The private sector people on the task force tended to support the broader solution. Unfortunately, the groups in the private sector that did oppose a major change in financing were the state medical society and the state hospital associations. Small business supported the broad approach because they didn't like the mandated benefit option. Large business also supported it, but the governmental people all opposed it. In my opinion, the failure was not within the task force but within society. Clearly we lacked a strong enough power-oriented constituency to persuade the Democratic administration that this was a vital issue.

To summarize the issues discussed, the themes of this conference have focused on the problems of financing health care and how to deliver health services. While these themes are very much interrelated, we often let the financing issue dominate the discussion and our actions. We fail to realize that there is a lot of money in the health system now and we are not using it nearly as wisely as we could. There are also many good people working in the health care system and in community agencies who are not utilized as wisely and intelligently as they should be. While we must move forward on the financing front and we need money to support our services, we must also make better use of the dollars and the people we have now. Keep in mind—"the only thing necessary for the triumph of evil is that good men and women do nothing."