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The enormous impact of our known national debt on our future as a nation has received a great deal of concerned commentary from observers of practically every political persuasion. We contend that there is a more hidden, more difficult to measure national debt which has developed over the last decades. This is due to our lack of willingness to develop appropriate funding for health care in urban areas populated, in proportion, by persons who are either uninsured or underinsured.

The above assertion assumes that the "common assets" of our society include not just those within the government sector but also the not-for-profit institutions which provide a basic societal need. In a city such as Detroit, *a substantial percentage of the health care provided to the underprivileged has become the responsibility of not-for-profit hospitals.* In a for-profit corporation, profits are distributed to the shareholders. In a not-for-profit enterprise, society is the shareholder and that which is considered owners' equity in a for-profit business belongs to society as a whole (represented by trustees). Profits or deficits are applied to the mission, and in the case of deficits the mission is allowed to be compromised. As is the case in a for-profit business, the not-for-profit enterprise can use up owners' equity in an attempt to meet the demands placed upon it by society. In effect, society can say to a not-for-profit organization, "We want you to meet a continued social need, but we are not able to provide you with an adequate revenue base for doing so. Instead we would like you to meet those program objectives out of owners' equity." Thus society can decide to bankrupt one of its own "common assets." A common shape that this takes is for government to reimburse for care of the underprivileged at a level which permits no operating margin. Since that as well as depreciation are the two major ways of defining available capital (in a capital-intensive business), that level of reimbursement, in effect, puts that institution out of business.

For the city of Detroit, this is not an ominous possibility but a current reality. One of Detroit's most venerable institutions, Mount Carmel Mercy Hospital, which had 597 beds, was forced to close its doors this year, and others are threatened. In hospitals not yet closing, the ability to renew and maintain capital has been restricted, and their mission is jeopardized.

The Crisis Facing Urban Hospitals

Urban hospitals have had to face some sizable threats in the past decade:

1. A disproportionate number of urban hospitals are teaching institutions, and the "educational pass-through" from Medicare and previously from other third parties was actually a proxy for dealing with the less easily measured higher costs of inner-city health care. As senior staff in most urban areas are increasingly scattered to more remote suburbs, the presence of house staff is more important than ever. Yet the federal government, recognizing that there is no substantial need to increase the physician pool, has placed this source of revenue under pressure.

2. Many urban hospitals relied on a Robin Hood approach to the care of the underinsured by using paying patients to provide operating margins sufficient to give away some free care. This is no longer sufficient for several reasons. First, in most major American cities, the paying patient has been cut off from the urban hospital by a ring of high-technology suburban hospitals which handle most of the high-profit diagnostic and therapeutic procedures such as coronary artery dilatation and bypass. This type of institution rarely has any research and development expenditures, relying almost entirely on technology which was developed elsewhere. It rarely has any substantial charitable commitment and thus is able to reinvest in increasing amounts of established technology. Second, those private patients who do

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manage to find their way to the urban institution are often covered by insurance which is finding ways to avoid meeting needs other than those of the insured (or managed) patient. Third, as the urban hospital learns to adapt to the societal needs of the inner-city dweller, some of those adaptations and the atmosphere created by a different culture keep substantial numbers of paying individuals away from urban hospitals.

One of the most successful ways of dealing with the problem facing urban hospitals is to become part of a system which has sufficient presence in a variety of areas with different social demography to permit internal transfer of resources. Perhaps the most substantial example of that is the Henry Ford Health System. However, different types of legislative recognition would be necessary for systems of that type to reach their full potential, and, even then, they will likely be competing with other systems that do not have a major urban commitment.

Outpatient Care in the Inner City

In most American cities, government-run clinics form a relatively small percentage of the care provided to urban residents. Many private practitioners, who have the mobility of a small individual business, have moved to more affluent areas, although they have viewed with alarm the later effort by group practices and academic institutions to do the same. Substantial numbers of dedicated private practitioners remain in urban areas, but they are operating against Herculean odds to survive. It has been said Detroit now has less than half the number of black obstetricians in private practice compared to 10 years ago. The malpractice climate in this region, of course, has some bearing on that situation.

Various "free" and charitable clinics exist in most cities. One example in Detroit is the St. Frances Cabrini Clinic which is a no-fee, no-questions-asked urban clinic staffed by members of the Henry Ford Medical Group for over 20 years as a charitable commitment. These types of clinics tend to be small, incomplete, and low in technology. Although they help somewhat with primary access, they are hampered by a lack of access to the next layer of care.

Hospital emergency rooms provide a fair amount of the ambulatory care that is offered in a city like Detroit, but the care is fragmented and lacks preventive services. For example, a child probably could have 70% of her health care needs met in an emergency room like that at Henry Ford Hospital, but her care would be lacking in a system of immunizations and parent education.

Public health nurses provide a considerable amount of care in a city like Detroit, but their services are coming under economic constraint and are substantially limited to certain subsets of the population.

Urban clinics run by universities, or group practices such as the Henry Ford Medical Group, are principal survivors in the urban scene. Often this type of organization has such a heavy capital commitment in the urban area that it is difficult to leave even if it were not constrained to stay due to some institutional altruism. The problem these clinics face is that they used to be subsidized by still-profitable urban hospitals. As profits for the urban hospitals have dried up, pressure on these types of clinics to "improve their payer mix" is increasing.

The Case for Reform

Relative to the urban provider community, society has permitted deterioration to the point where reform will require a sum of money not rivaling the established national debt, but certainly enough to suggest that society has forced not only its government to borrow against the future but also its not-for-profit institutions to use up their own resources without adequate replacement reserve, thereby imposing upon itself another substantial debt.

Meanwhile, another type of debt is accruing. "Deferred maintenance" for human beings can have consequences substantially more expensive than timely maintenance. Limitations of current expenditures for inner-city health are creating a substantial pool of later health problems for which the next generation, which is already burdened with the formal national debt, is going to have to pay for one way or another.

Those of us who work in inner-city clinics can point to hundreds of patients whose expensive strokes could have been prevented by a reasonably adequate blood pressure screening and management program, or whose inoperable cancer could have been detected by a modest screening program, or whose gastrointestinal hemorrhage could have been prevented by a modest, widely available substance abuse program, or whose disordered personality could have been ameliorated by a program dealing with domestic violence. What we are talking about here is the application of existing knowledge and reasonable technology to the entire underserved population.

We contend that our society is building up a debt to itself relative to health care of such scope that action, at least as urgent as that now being applied to the federal budget deficit, be undertaken. It could be argued that some of the events described have a "bright side." The number of urban hospital beds has been reduced, but because it was done for the wrong reason and in the wrong way, it left in shambles much of the urban ambulatory effort supported by those hospitals.

Some Proposals

We propose several suggestions for reform as it relates to urban medicine as we have lived it with our patients:

1. The financial support vehicle needs to be broader, more consistent, and simpler. Those of us at the St. Frances Cabrini Clinic constantly deal with individuals who "had Medicaid last month" but who have since lost their eligibility because of aging out of the dependent category or some other glitch in the criteria, even though their circumstances have not changed substantially. Qualifying, and remaining qualified, for Medicaid seems to be a difficult bureaucratic hurdle for many of our patients. Wayne County has developed CountyCare, a program which is possible only because of the unavoidable subsidies (in the form

of patient care) given to it by not-for-profit hospitals which are not participants.

2. The provider vehicle needs to be simpler and easier to use. A *very* sophisticated poverty-level person in Detroit could accomplish much of what she needed from a health point of view if she could wend her way from one facility that assists breast-feeding mothers, to another that does free chest films, to another that will provide pap smears, to yet another that will immunize her children. These facilities, of course, may not be in the same part of town.

3. Another area of inadequate commitment is preparing individuals to serve in urban areas. It is recognized that most and possibly the majority of health care professionals prefer working in upper-middle-class areas. For physicians, the reasons are numerous but often include geographic proximity to their homes, the ego gratification of being needed by one's social peers, considerations of personal safety, noncompliance on the part of the patients, and concerns about reimbursement. The very institutions that have the capability to train individuals to serve urban health care needs are themselves under considerable financial pressure.

4. We need to train a cadre of people to deal with urban health care issues. These people must have, as part of their training, a knowledge of epidemiology, preventive health services, methods of assuring compliance for unsophisticated patients, and improvements in tracking systems. Individuals with this kind of knowledge must include physicians, nurses, and social workers. These are the types of individuals who will be needed in the aforementioned urban health centers. Training grants for institutions with meaningful proposals for training such individuals need to be made available.

5. A more developed program for hearing the voice of the population for whom these programs are intended to serve needs to be instituted. Also, the boards of institutions heavily involved in urban health care should include some persons who have knowledge of and commitments in the areas of urban health.

6. Public health departments and urban health care institutions all should respond affirmatively to the Health Care Initiative in the 1990s proposed by Dr. Louis Sullivan, Secretary of Health and Human Services.

Further fragmentation must be *resisted*. We must resist the development of clinics in schools, geriatric boutiques, and so forth, even though all of these have been worthwhile as interim steps to an adequate system.

The solution is to be found in what Dr. Louis Sullivan has described as one-stop shopping for the urban dweller. This can be similar in many characteristics to the Henry Ford Health System's substantial suburban group practice-based satellite system. Among the characteristics that should be emulated are:

- Ambulatory facilities which are open 24 hours a day for urgent care and which have extended hours for all care.
- A reasonable range of specialties.
- Managed health care as the principal modus operandi.
- Reasonable geographic distribution.

Elements of this system which would be different from a Henry Ford Health System-style of satellite include:

- An even stronger program of patient education.
- A superior patient tracking system to be sure that the target population receives on a timely basis pap tests and prothrombin times, and so forth.
- A stronger social work department.

Now is the time to begin planning pilots for a system of this type. Now is the time to end the stalemate on how to provide health care to the underprivileged. Bringing more efficiency and health maintenance to the system will save some dollars, but not enough to avoid putting more dollars into the urban health "system" as a down-payment on reducing our otherwise inexorably increasing health debt.

Society as a shareholder has certain responsibilities to the mission. Has a conscious decision been made to abandon the mission in our major cities, or is it simply that our shareholders are uninformed? It is an inconvenience when major supermarkets and department stores abandon the city, but it is disheartening when youngsters in the city are poorly educated compared to those in the suburbs. In the case of health care, the mission translates fairly easily into human rights. Providers have the responsibility to inform and to present feasible alternative systems for health care, and society has the responsibility to protect its "owners' equity."