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POSITION PAPER - HEALTH
Urban Coalition Roles in the Health Field

BACKGROUND

While no one wants to be sick, among the desperate needs of the urban poor and disadvantaged, seeking good health, including practicing preventive medicine, will not be perceived as a very high priority. They find as more compelling needs, jobs, the opportunity to own a business, more educational opportunity and better housing. Since without good health, daily functioning in holding jobs, running households, attending school and the like, is difficult, if not impossible, various kinds of health services are a necessary condition for the poor to function with any adequacy at work, at home and in their communities.

There is much evidence of the deplorable health status of the urban poor. "Poor" refers to all those families, including about 25 million individuals whose income falls below the commonly accepted government standard that would provide adequate food, clothing, and shelter and medical care.* The disproportionate

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*Of an estimated 45 million poor people, half live in large metropolitan areas. Another 25% of this total live in concentrations of population but non-metropolitan areas. Our primary concern is with the improvement of the health services in the cities that serve at least 25 million Americans.

prevalence of ill-health among the poor, minority and disadvantaged groups is shown in many ways:

--Death comes earlier to the poor. Life expectancy for the non-white is 7 years less than for the white.

--Death is a more frequent visitor to poor mothers and infants. Non-white mothers die in childbirth 4 times as frequently as white mothers. Infant mortality is twice as high among the non-white as among the white.

--Illness is twice as frequent among families with annual incomes of $2000 or less. There is 4 times as much chronic illness among these families, twice the number of days of restricted activity, a third longer hospitalization.

--Tuberculosis and cancer of the cervix is found twice as often among non-white urban residents as among the white.

--Visits to doctors and dentists, despite the obvious greater need, are less frequent among the urban poor. Children under age 15 average half the doctor visits in families with incomes under $2000 compared with children of the same age in more affluent families.

--Preventive services are not received by the same proportion of poor children as they are by the more affluent. Only 8.6% of white children have no immunizations compared with 22.5% of non-white children.

Existing health services delivery systems do not reach all of the urban poor. Medical care is generally provided in clinics

where available, generally over-crowded, at inconvenient hours, understaffed, and run as categorical units: i.e., diabetes clinic, heart clinic, arthritis clinic. Care is episodic, focused on emergencies rather than continuous and comprehensive, with little if any attention to preventive services, or health education. There is little or no effort to reach those who need care, but lack motivation. There is little if any follow-up, coordinated control intake, or referral procedures.

Where private doctors' offices are the source of care, high costs deny needed services to many. While Title XIX (Medicaid) has been in effect for a number of years, not every State has yet participated, and even where the States have, legislative ceilings both Federal and State have imposed stern limitations. Less than 9 million people altogether in the country are covered and able to take advantage of the program. This means that for the other millions of the poor, the doctor's bill may strongly deter their seeking care.

In addition, the clinics and doctors offices are not available to all. Many inner city neighborhoods are far from where hospital clinics were set up a generation or more ago; doctors have moved to the more affluent suburbs; public transportation from many of the inner city neighborhoods is lacking, insufficient or expensive. The shortage of health manpower generally is well-known, and the shortages of physicians and nurses, and other health personnel have been well publicized.

The problem of accessibility of health care facilities is compounded in those instances where governmental and private agencies and instituitions have failed to reorganize to meet the personal health needs of the poor. In addition to the fact that facilities are often absent, obsolete, or obsolescent, inadequate in scope of service or availability temporally or geographically, emergency services are difficult to obtain, inadequately staffed, qualitatively inadequate.

Environmental health needs are only minimally met. The problems of air and water pollution are largely ignored. More personal environmental needs such as damp, cold crowded housing are widespread among the poor. Garbage and waste disposal is inadequately supplied. Rats abound, as do other pests. Most of such conditions result from failures of local policing and supervision.

Federal aid does not serve local health agencies effectively. In the past five years, a spate of Federal legislation has been enacted and the amounts spent by the Federal government in the health field have been tripled. At the same time, because of the multiplicity of funding sources and the complexity of approach, including the proliferation of planning bodies, local units were and are unable to take full or even partial advantage of the resources available. Furthermore, the new legislation looked to modification of the local organization and new methods for the delivery of health services that existing service agencies were completely unprepared to undertake.

Hunger and malnutrition can be both a concomitant to illness or a direct cause of it. Malnutrition is known to interfere with proper growth of the fetus in the mother during pregnancy, with the health of the pregnant woman, and is responsible in some degree for the higher maternal and infant death rates among the poor. Malnutrition is known to be associated with improper development of the growing child physically and mentally, and is responsible in part for the increased illness among the children of the poor, their learning difficulties in school, their later failure to find adequate employment and in adult life, their increased chronic illness.

Some 25 million people must be counted among the poor and the near poor, yet nowhere near that number qualifies for, or lives in communities that operate, Food Assistance Programs. Only about 8 million actually receive food assistance, through commodities distribution or food stamp programs. Commodity distribution has been attacked as nutritionally inadequate, culturally unsuitable, and logistically impractical. Food stamp programs are hedged about with requirements of time and place and quantity of purchase reducing their coverage. School lunches are not free to millions of children who cannot purchase them even where they are available. Some districts specifically exclude families on welfare from free school lunches for their children. Hundreds of counties where desperately poor people live have no food programs at all. A study of welfare food cash allowance in a report last year from HEW demonstrated its inadequacy even for the poorest of the poor who

qualify for welfare aid: the food prices are based on 10-year old costs, or else the State or local welfare payment is only 18% or 50% of the State's own admitted level of need.

KEY ISSUES

The health of residents of the inner cities cannot be served by health programs alone. Education, including health education and nutritional education, improved housing, more and better skill training, finding and retaining jobs, are integrally related needs. However, as already stated, significant and substantial progress must be made toward meeting each of these needs, but those ends will not be achieved unless simultaneously progress is made toward providing more adequate health services.

To achieve the progress that will better conditions in the cities and will reduce tensions in urban centers requires reassessment of responsibilities to be borne by the various elements involved in delivering medical care services:

What responsibilities can the private practitioners of medicine assume for improving the health of the urban poor.

a) For locating offices accessible to the poor, and using non-professional aides from among the poor to serve the poor in their offices?

b) For limiting the charges which deny medical care to many?

c) For reaching out to the needy, rather than passively waiting to serve?

d) For looking toward group and team services as a pattern of practice?

What responsibilities must government assume for improving the health of the urban poor?

a) For expanding the supply of trained health manpower and stimulating the use of new and more imaginative combinations of health workers to increase physician productivity?

b) For providing needed health facilities, emphasizing interrelated institutional needs?

c) For assisting individuals to meet the costs of essential medical care?

d) For establishing goals and priorities in health services?

What responsibilities must hospitals and medical teaching centers assume for improving the health of the urban poor?

a) For developing a full spectrum of institutional services?

b) For modernizing educational opportunities to increase their productivity, and recruitment policies more applicable to the poor?

c) For outreach services and programs beyond their walls?

d) For continuing education?

What responsibilities should business assume for improving the health of the urban poor?

a) For eliminating air and water pollution?

b) For improving existing housing conditions?

c) For using their influence in Board membership of voluntary and public agencies to facilitate needed change?

It has become increasingly clear that the absence of representatives of the community in the councils and committees that decide on policies, devise plans and programs and carry them out, is a serious flaw and probably contributes heavily to the failure or inadequacy of existing health programs. Priorities and allocation of resources cannot be appropriately assessed if not related to the community of discourse, as well as professional considerations. This is true of the poor, of all minority groups, and even more so where profound cultural and language differences exist. The involvement of poor whites and poor blacks is essential in decision making on health planning and programs, the involvement of Spanish speaking people in Mexican-American and Puerto Rican communities, the involvement of Indians in their areas of residence.

POSITIONS

The existence of the Urban Coalition is based on the belief that concerned citizens wish to contribute to the process of changing institutions where the evidence of their inadequacy in dealing fairly and justly with all citizens is demonstrable. The failures of the health service system to deal fairly and justly with the poor is demonstrable. Change in this system will require painful readjustment, but is long overdue. It will not be enough

to recognize the defects in someone else's operation. Sacrifice of traditional modes of thought and behavior will be expected in one's own part of the whole. Recognition on the part of each element involved, of his own deficiency is basic to change. Professions will be asked to re-examine their patterns of practice, reimbursement, recruitment into training, and the training itself. Institutions will be asked to review the services rendered, the staffing relationships, the interaction with other institutions, independence and responsiveness to community need. Governments will be asked to investigate their allocation of funds, evaluation procedures, program decision making and coordination with non-public bodies. In every instance the expert must expect to be questioned by the "beneficiary", or his advocate, in this case the sufferer from the deficiencies of the system, and reply as to whether his action or position is to benefit his narrow interest or the larger goal.

Aware of prevailing health conditions in this country's metropolitan centers, and the drastic effect of these conditions on the quality of life in the inner cities, the Urban Coalition believes that:

1. Efforts must be redoubled in each city to make it possible for all citizens to have access to modern medical care. This will require that:

a) Each community, with the aid of Federal assistance for "comprehensive health planning", should diagnose available health

resources and identify the areas and the groups for whom medical care services are most needed and least available;

b) Coordinate existing services so as to eliminate duplication and make more efficient use of resources;

c) Initiate programs where now lacking, or introduce transportation where required to offer access to health services;

d) Extend existing services, particularly making clinic services available at opportune times;

e) Involve community residents in planning and delivery of, and outreach services, particularly use of the poor in reaching the non-users of care.

While no single method or plan will fit all communities, no potential opportunity must be overlooked. More convenient clinic hours, better transportation, more facilities nationally interrelated, more efficient use of Federal and other public funds, more realistic use of staff available and production of necessary manpower locally should all be explored.

2. Concentration on improvement of special programs with particular relevance to the needs of poor people. Here action is needed on the part of all related health agencies to extend and improve prenatal care and infant care services, school health services, case-finding of handicapping conditions and coordination of health service to treat orthopedic handicaps, provide glasses and other appliances. Major emphasis must be to improve mental

health services and community programs for care and rehabilitation of the mentally retarded and emotionally disabled, returning them to homes and jobs as quickly as possible. More home health care is urgently needed. Family planning efforts must be intensified.

For all health services related to children, for example, the school can be used as a center for identification of cases, provision of care, and community involvement in health care. This will require a new focus on the part of granting agencies, planning groups and health service agencies. However, the school is where the children are, and where mothers can be reached. While the present turmoil in education might be prejudicial to adding this concern to the already complex discourse, it may also offer a ready-made vehicle for change in health services. It deserves serious consideration.

3. No child should go hungry. No adult should be without needed food. To ensure these ends will require:

a) Consolidation of local resources to eliminate hunger. Every community must have a supplemental food program, and a case-finding program to identify all families and individuals whose resources are insufficient to provide them with the minimum required basic standard nutriments.

b) Existing Federal aid should be utilized to the fullest. That will necessitate the sharing by governments, in the administrative cost of stamps, commodities or free lunches and breakfasts, and nutrition education.

c) Private resources, in addition, should be sought and used where needed.

4. Environmental hazards and disease-producing agents must be eliminated. This requires that large scale air pollution and waste disposal problems must be more vigorously attacked by public agencies. This attack should include the establishment of more rigorous nationwide legislative standards and aiding and requiring private business to eliminate their pollution of the atmosphere. Much of the clean up, rat control, garbage disposal and elimination of pests and nuisances that make the surroundings of life in poverty unpleasant and prone to added illness, can be dealt with through added specialized manpower: housing aides for inspection, sanitation aides for education and clean-up.

5. Expand the essential supply of health manpower through interaction with local educational institutions and health service bodies. A great deal of the community work that needs to be done in taking care of the non-professional aspects of personal health care, such as home health aides, interpreters, new kinds of technicians, the elimination of environmental hazards and the case-finding aspects of nutrition and handicapping conditions, the educational aspects of health, and nutrition can be carried on by specially trained local people. In addition, through community conferences with medical school leaders and schools of public health, the opportunities can be developed for increasing the supply of physicians, nurses and public health workers. This should apply particularly to the possibility of recruiting local poor and disadvantaged into these health careers.

6. Modification of Federal policies for health facility construction and modernization. In order to provide the health facility base from which the improved and expanded health services are to be delivered, the present Federal health facility policy as exemplified in Hill-Burton legislation must be modified. Facilities grants must be less retrictive, more applicable to the needs of the inner cities, offering a larger Federal share and directed toward comprehensive services, particularly ambulatory care components. Loans and loan guarantees will not benefit public hospitals sufficiently because of the problem of tax exempt bond issues. Loan and interest repayment inflate per diem costs. For large city hospitals serving the poor, grants of up to 100% will be needed. Grants will have to be available directly to cities, or priorities in the Federal legislation or administration changed to favor big city hospital modernization and ambulatory care service construction.

7. Expansion of Federal health programs is essential to meeting the health needs of urban dwellers. There is special need for:

a) Increased insurance and Federal funds through Titles XVIII and XIX and other programs for the money required to pay for added needed services to the poor;

b) Improving the organization of health services for all, but especially the poor through neighborhood health centers, and

continuity of care especially in the stimulation of group practice, particularly with prepayment.

c) The modification of medical education to hasten the increase in enrollment of waiting applicants to medicine.

d) Improving the wage and employment conditions of health workers so as to attract more young people and particularly the disadvantaged, into health careers.

e) Correspondingly improving the junior college and college opportunities for training in the health careers.

f) Expanding food programs that are geared to established scientific standards and not arbitrary means tests.

g) Eliminating air and water pollution.

h) Improving the total environment.

In brief, the Coalition will strive to:

--Aid local communities to make the best possible use of existing resources;

--Bring about expansion of health services for mothers and children;

--Intensify Federal efforts to assist local communities in improving their health facilities and services;

--Obtain additional appropriation to finance medical care for the residents of the inner cities;

--Eliminate barriers to access to adequate supplies of food;

--Strengthen Federal programs designed to add health manpower to the pool available for service to residents in the inner cities;

--Press for greater citizen participation in community health service decision making and operation.

Short-term, immediate objectives should include all local efforts to improve clinic services keeping in view the long-term objective of comprehensive group practice, prepaid, possibly through neighborhood health centers; developing realistically defined entry level job opportunities coupled with health career development opportunities; improved food distribution programs combined with emphasis on long-term objectives of pay or public assistance programs of whatever kind that provide enough money to buy enough of the right kind of food.

To achieve these goals, the Urban Coalition is developing and will shortly publish, a "R_x for Action", offering local coalitions a wide range of choices in various areas of action to improve health services; technical assistance through publications that will aid in accomplishing the ends prescribed in the manual; and consultant services to stimulate and support local coalition health activities.