SELECTED PROCEEDINGS FROM THE NOVEMBER 1989 URBAN HEALTH CARE SYMPOSIUM

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America's health care delivery system is ill-suited to meet the needs of urban populations. State and federal government, employers, insurers, public health officials, and health care providers all are demanding change. The mandate for the 1990s is clear: new models of financing and delivering health care must be adopted.

As we enter the last decade of this century, we face the challenge to design a comprehensive health care delivery system that will meet the needs of all Americans. Health care must not be considered a privilege but a right of every citizen. For decades our country has been struggling to make this a reality, but short-term solutions and band-aid approaches have proved ineffective. The facts clearly point to a need for reform in our health care system; more than 31 million Americans have no health insurance and an even greater number have inadequate insurance. Progress in reducing infant mortality is slowing, and the gap between the health status of minority Americans versus white Americans may be widening. From the perspective of urban hospitals, the issue of survival is paramount. Emergency rooms are overcrowded and facing gridlock. Medicaid cutbacks and rising levels of uncompensated care threaten the existence of hospitals across our nation. Many have been forced to close and others continue to be threatened.

The need for health care reform is great. Health care providers and public health experts must begin to speak out on this issue, for it affects the very survival of our nation's people and health care delivery system.

In an effort to address the crisis facing the urban health care delivery system, Henry Ford Hospital organized its first urban health care symposium, "Urban Health Care: Solutions for the 1990s." Selected proceedings from this November 1989 conference, featured in this issue of the Journal (pp. 101-182), focus on three main themes: delivery of care, special needs of vulnerable populations, and financing of care.

New delivery models must be developed and tried. They must address the root causes of health problems, while simultaneously dealing with issues of access, quality delivery, and financing care. Initiatives involving managed care models, community-based programs, and health education and preventive health efforts must emerge in order to assure access and efficient delivery of quality care for all patients.

Any solution to the health care issues facing urban populations must address the needs of special population groups. These needs include timely access to care for disadvantaged members of minority groups, maternal and child health, and the special problems associated with the acquired immunodeficiency syndrome (AIDS). Those of us in health care are all too aware of the impact that AIDS, violence, and drug abuse have had on our ability to serve urban populations.

Developing strategies for financing care must include an analysis of current methods that do or do not work. It seems unlikely that existing financial schemes can solve the problems of the uninsured and underinsured. Instead, entirely new approaches may be adopted at state and federal levels. A variety of approaches for dealing with the financial crisis have been suggested, including variations of some state government initiatives and federal options such as national health insurance.

In our search for solutions to the urban health crisis, an alarm has been sounded. As Dr. Reed Tuckson, our keynote speaker, stated, "health is where all social issues converge." If we are to have an impact on health status, we must address the root causes that contribute to the deterioration of our people and our health system. With health status being a major determinant in the vibrance and vitality of a city, we must engage our communities in solutions that address self-induced illness and limited self-esteem.

To be successful in the 1990s, health must become a priority on the national agenda. It is incumbent upon everyone in the health care field to communicate that message. The need to improve financing and coordination of care is pressing hard upon our urban hospitals. Both urban and suburban hospitals must work together to learn how to better serve the needs of inner-city communities.

We must be aggressive and speak out to change the system. We must be catalysts to build coalitions in our communities to help solve the problems. Community coalitions can change the urban health scene. These coalitions must include hospitals, physicians, public health agencies, community agencies, neighborhood representatives, church leaders, elected officials, and many others. It should not be an exclusive club. We cannot plan or play in isolation. It will take time and great will, but we must be persistent.

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Guest Coeditors
In addition to effectiveness of service, distribution of health resources, and the economics and financing of health care, social justice and equity is another emerging issue in health care. The United States health care policy—or, better stated, the absence of a health care policy—was one of the greatest contradictions of the 1980s. As a society we spend more for health care and provide less coverage. Nationally, our health care expenditures, whether measured by gross national product or by per capita expenditures, vastly exceed health care costs in other countries. We also stand alone, excluding South Africa, in not having a national health care policy for children. Currently 37 million Americans are without basic health care coverage, a number that has increased by 25% since 1980.

Michigan's task force on access to health care recently commissioned a statewide survey to determine the extent of uninsurance and underinsurance in the state. The study found that nearly 11% of the state’s population are without basic health care coverage (1). Of these 940,000 people, nearly one-third are under age 18, 66% work full- or part-time or are temporarily laid off, and two-thirds live on incomes below 200% of the poverty level. There is every indication that the number of workers, families, and children without basic health insurance will continue to increase dramatically unless we take decisive action. A growing number of low-income taxpayers are paying for others' health care either through their own taxes or public assistance programs or through the increasing prices in the marketplace as the cost of indigent care is passed on to paying customers.

**Failure of the Health Care System**

The social justice and equity issue goes beyond uninsurance and underinsurance. Our country's public health care programs and policies are fragmented. We have developed public programs based on complex categories, family status, diagnoses, and age instead of on the health care needs of the population and the ability of the people to pay for these services. This has resulted in a maze of programs with growing gaps in services and an increasing number of Americans left without basic health insurance because they do not meet the categories of care. This outcome is costly for the federal and state governments and has produced chronic underfunding. In Michigan, as in many states, the Medicaid program is the largest single program in the state budget, and funding is consistently reduced when the budget gets tight.

Our failure to address systematically the health care needs of vulnerable children and adults is all too apparent when measured by health status. The access to health care task force survey (1) found that those people without health insurance are significantly more at risk of having poor or fair health than those with private insurance.

The failure of the health care system also can be measured by infant mortality statistics. In Detroit, some neighborhoods have infant mortality rates that are among the highest in the nation. A recent epidemiological survey conducted by the Michigan Department of Social Services and the Department of Public Health (2) assessed why children in Michigan die. Of the 8,740 deaths between 1984 and 1986, 68% were disease-related, with birth defects and perinatal conditions being the leading causes. Children under age 5 years die of disease at a much higher rate than any other age group. Poor children are particularly at risk, with a mortality ratio of 2.5:1. The ratio climbs to 3.2:1 for perinatal conditions.

Failure to provide health care also can be measured by opportunity lost: children without basic health care services who enter school ill find they are neither competitive nor prepared to mature into adulthood. As adults, they suffer chronic illness and face a lifetime of dependency.

Those are the grim facts, but there is hope. Better organized and more intensive programs can have an impact. In Detroit, an intensive prenatal care program that provides services through the first year of life for at-risk infants has dramatically reduced the infant mortality rate for the population surveyed from 15 per 1,000 to less than the state average.

**Reforming the Health Care System**

Unlike many social and health programs, aggregate expenditures for health care services, excluding long-term care, are sufficient to provide comprehensive coverage for people at risk. A study by the University of Michigan determined that approxi-
Ultimately $1.4 billion are spent in excess, direct or indirect, of administrative costs each year (3). If those dollars were redirected into more streamlined services that included a cost-containment component, there would be sufficient dollars to provide basic health care services to those people in Michigan without health insurance today.

There is growing public concern about the fragmentation of services, the number of people with inadequate or no health insurance, and the need for major reform of the health care system.

In the 1990s we must focus on establishing a national health care policy that will bring the United States in line with the rest of the industrialized world in providing health care as a basic right for all citizens. The policy should emphasize equal and universal access without discrimination based on age, type of disability, or family status. It should be based on a federal and state partnership to ensure that the basic policy is available to all Americans.

There are some interim steps that need to be taken at the state level. First, we need to ensure coverage for all children. There is no good reason to have 300,000 children in Michigan and 12 million to 13 million children nationally be without basic health care coverage. Through the expansion of Medicaid, the development of dependency coverage policies, and better regulation of private insurance, the gap can be closed.

Second, state-sponsored and state-supported insurance plans for those particularly at risk must be explored. In Genesee County (an industrialized county located in Flint, MI) and Marquette County (in Michigan’s Upper Peninsula) the state is experimenting with a program called the Health Care Assistance Project. Through a grant from the Robert Wood Johnson Foundation, the state assists small businesses with 20 or fewer employees in providing health insurance for their employees. Under the state-subsidized program, each party (the state, the employer, and the employee) pays one-third of the cost of the health insurance until the employee earns more than 200% of the poverty level. As of November 1989, 116 employers have stepped forward and are now providing insurance for their employees for the first time. For the state, the subsidy comes at an extremely reasonable price of less than $22 per month per individual for full health care coverage. We found that the cost was a critical factor in determining whether or not the employer would provide a particular service or benefit.

Another special insurance program which was recently initiated in Detroit allows individuals with the acquired immunodeficiency syndrome to continue their health insurance coverage through a subsidy to help those below 200% of the poverty level and those at risk of losing their private health insurance because of loss of income. The program helps these individuals pay their insurance premiums in order to protect their insurance rates and to ensure that they do not become impoverished, lose their health insurance, and become reliant on Medicaid.

Several states are also initiating transitional benefit programs. Such programs allow families who leave public assistance because of employment to remain on Medicaid for at least one year. The Michigan legislature currently is considering a bill to extend the program to 48 months. Of the 25,000 people in Michigan whose Aid to Dependent Children grants were closed in 1988 due to employment, about 60% went into jobs that did not offer health care benefits. In addition, 80% of those who returned to public assistance because of loss of income came from jobs without health care benefits. Health care insurance has become a fundamental fringe benefit which is disappearing as the job mix in society changes.

Intensive support services can make a difference in the lives of children who are at risk. Michigan has proposed the Sentinel Services to follow up for one year children at risk because of substance abuse, failure to thrive, low birth weight, or the age of the mother to ensure the children receive the care they need.

A key component in accomplishing any of these initiatives is cost redirection. Any health care policy that adds to costs and does not systematically change the basic way services are funded will not be acceptable to the public, the government, industry, providers, or third-party payers. A major factor in cost reduction is hospital bed reduction. Any system that is 40% empty on a given day is inherently costly, and these dollars can be redirected toward direct health care services. This will require a great deal of discipline from all of us, particularly those who provide hospital services. We cannot push to expand suburban hospitals that have only 60% occupancy when hospitals in the central cities can provide the needed services. An all-payer hospital reimbursement system must be considered in Michigan and other states. It makes no sense to reimburse through Medicaid at one level, through Blue Cross and Blue Shield at another level, and through commercial insurance companies at yet another level.

**Time for Change**

Congress as well as state legislatures need to deal seriously with the health planning issue of expenditure targets at the federal and state levels. These are difficult issues, whether in the arena of developing a national health policy, taking interim steps, or moving toward cost containment. They will not be accomplished without pain or without great political compromise.

The basic question for the 1990s is not whether the current system is acceptable but when the system will start to fail too many people. Our responsibility as leaders in the public and private sectors is to provide the direction for change and to put aside self-interest in order to develop the principle that health care services should be a basic right for every child, every family, and every individual in our society.

**References**