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Every city in the United States contains an array of medical personnel and technologies that would be the envy of many nations. Despite this wealth, broad tracts of our cities are degenerating into public health emergencies that seem to worsen year by year. The more we understand this evolving crisis, the less significant appear the distinctions between our individual institutions and disciplines. For example, emergency room overcrowding is clearly no longer a function of an individual hospital's efficiency but of local access to primary care. Rising infant mortality from the acquired immunodeficiency syndrome (AIDS) is more directly addressed as an issue of drug policy than of pediatrics. The recognition of the multidisciplinary demands of these and many similar issues has led the Urban Health Committee of the Medical Care Section of the American Public Health Association (APHA) to grow rapidly from a small collection of physicians to more than 600 members, including community organizers, nurses, health services researchers, epidemiologists, hospital chief executive officers, political scientists, medical educators, and others. The leaders of the Henry Ford Health System have also recognized this important feature of the urban health crisis and invited members of the Urban Health Committee to participate in the Urban Health Care Symposium II.

Committee members submitted many papers on the broad theme of urban health solutions. Given the diversity of participants and the dimensions of the crisis, AIDS educators will hear about physician recruitment and hospital administrators will learn about the relationship of chronic stress with illness in inner-city populations. In one sense this is as it should be, because we are not addressing a system of health care in the inner city; we are addressing a nonsystem. Ideally, we each should be able to work hard on what we know best, but in the current crisis we are forced to undertake many roles. As an urban family physician, I must also be a savvy administrator, a community health educator, a politician, and an amateur social worker. Responding simultaneously to the increasing stresses on our patients, our institutions, and our communities takes its toll. Over time it threatens our ability to care. The burnout of our colleagues testifies that dedication to the care of the needy, while necessary, is not sufficient. We need a system of urban health care that is both effective and satisfying, not just good intentions. Each paper presented at the Urban Health Care Symposium II sheds light on important parts of that system; my comments address some of the broader issues we must confront in building it.

Twice a year when I edit the *Urban Health News*, I write surrounded by reports and clippings bearing depressing news. Rates of teenage pregnancies and urban crime are up; the number of urban hospitals is down; tuberculosis and AIDS cases are up; infant survival is down; crack use is up; social service budgets are down. Some conservatives insist that the contemporary urban crisis is actually a result of enhanced programs for the needy dating from the War on Poverty. Many liberals counter that inadequate funding has hobbled these programs. Can we really defend our nation's fragmented and incremental programs for the inner-city poor by arguing that increased funding here and a new program there will meet today's needs? I think not. The critical condition of our cities' health forces us to reexamine not only the myths of conservatives but those of liberals as well. Programs based on myths offer false promises, and the time for false promises has run out.

The first myth is that improving Medicaid or creating another segregated health insurance plan to include the poor and uninsured (such as that proposed in the Democratic leadership bill recently introduced on Capitol Hill) can bring the poor into the medical mainstream. For 25 years, Medicaid funding for the poor has languished in competition with more powerful constituencies ranging from the Pentagon to the nursing home industry. Recent increases in mandated Medicaid coverage now threaten to break state house budgets while failing to show significant improvement in health outcomes (1). Nor will these expenditures provide enough resources to increase access to care substantially in inner-city areas where capital investments for health services have lagged for decades. The concept of "separate but equal" in public education was discredited long ago. A "new, improved" segregated health financing plan for the poor only offers more false promise.

This realization has led many of us to support a universal health insurance program that covers all Americans without distinction. Allowing the poor equal access to insurance is a vitally important step. However, to rely on this change alone to meet

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the needs of underserved urban communities is likely another utopian false promise. Will universal health insurance really induce private providers of care to invest their money and careers in dangerous and overwhelmingly needy urban communities? Or will it result in a false sense of security that allows the nation to neglect safety-net services such as public hospitals and clinics while the private sector pursues more lucrative, less risky investments? Will the plan aid those institutions which have always delivered community-responsive health care for poorer or richer, such as community health centers? Or will better capitalized entrepreneurs and medical centers seize the opportunity to skim away the most profitable, newly insured patients from these providers, leaving, as always, the neediest as residue? Will funds flow to the difficult task of reaching ghetto toddlers with measles vaccine, or will they be exhausted on influenza vaccines for healthy teenagers in suburban offices? I fear that the medical infrastructure in many highly underserved urban (and rural) areas is so degraded, and the health needs of these communities so alien and overwhelming, that creating a level playing field in purchasing health services will not suffice to improve health care access. Indeed, at worst, the inadequate funding which today finds its way into these areas may simply be stretched further to serve also the demands of the working uninsured nationwide. For those of us who look ahead beyond incrementalism to a universal insurance plan, it is time we ask hard questions about what shape it will take and to model the effects of competing proposals on highly needy urban (and rural) communities. Perhaps I am too optimistic about the likelihood of such a plan, and perhaps I am asking too much of our busy economists and health services researchers, but the national debate must be informed on this point, and I think the time to begin is now.

Another false promise is that more categorical health programs will address the magnitude of the need we face. As a family physician, I do not see the sense of cholesterol screening on Tuesday, colon cancer screening on Wednesday, and providing mammograms every other Friday when I might provide for each of these in a 15-minute visit. Our poorest clients already have full-time careers visiting the welfare office; the Women, Infants and Children program; the public housing authority; the electric company; the hunger center; and the thrift shop. Offering more fragmented single-purpose health programs is crazy in this setting, producing little marginal gain. Such services need to be consolidated into convenient, accessible primary health care where one-stop shopping is a real possibility. The experience with consortia that strengthen and complement the services provided by community health centers represents one hopeful step in this direction (2). We have recently seen a most dramatic contrary proposal: the Bush administration's (defeated) plan to fund infant mortality reduction efforts in a few major cities by reducing the budgets of community health centers nationwide. Unlike most medical schools and medical centers, community health centers have a proven track record of improving the health of their neighborhood in a cost-effective manner (3). It is time for categorical funding to go primarily to such highly integrated health and social service centers instead of allowing monies to be siphoned off to universities and consulting firms. We need the community health centers and similarly comprehensive health service systems to sit at the center, not the periphery, of our public health initiatives.

One final myth is problematic because it actually supports our efforts to expand services to ghetto neighborhoods. This myth holds that adding more medical and social programs will play a central role in permitting ghetto dwellers to escape their poverty. We must know that our patients are the focus of escalating social scrutiny, policy debates, and general impatience. A popular and highly visible school of thought holds that inner-city ghetto residents have become an underclass in part due to social pathologies, such as bearing children out of wedlock, that keep them mired in perpetual dependence (4). As these theories have captured public attention, they are often oversimplified to a ridiculous degree. For example, a recent newspaper editorial welcomed implantable contraceptives as a solution to the growth of the underclass (5). America is losing patience with the urban poor. Increasingly, those of us on the front lines are hearing the message, sometimes overt, often subliminal: fix the poor, or have them fixed.

If teen pregnancy and drug abuse were truly the causes of poverty, we might claim that medical intervention holds the key to our urban dilemma. But no health programs will reduce urban poverty so long as jobs with living wages aren't there. Those paychecks won't be there so long as jobs are exported to low-wage workers in other lands, or while productive capital is redlined away from the inner city. The capital for reindustrialization won't be there when the Department of Defense spends more in 40 years than the current worth of all civilian plants, equipment, and infrastructure (6). The decisions that perpetuate the urban health crisis aren't made primarily in the budget of Health and Human Services; they're made in international trade treaties, defense allocations, civil rights bills, and banking committees. The condition of the ghetto poor, their general well-being, is more dependent on the economic health of the city itself than any medical intervention. This does not mean that we have no role or that greatly expanded health and social programs are unnecessary—only that they are not enough. Somehow we must find a voice to make this clear to those who are anxious to "fix" the social pathology of the poor, those who cannot see this as yet another false promise. Otherwise, in time, high expectations may turn to disappointment, quietism, or worse, and our ghettos again consigned to a few more decades of neglect and lost lives.

This is not to say that the health care industry cannot play an important role in the economic revitalization of the central city. Most large medical centers and medical schools are surrounded by extremely needy urban communities. Ironically, in my hometown of Cleveland, the health industry is now the single largest employer in the region, overtaking the automobile and steel industries. Yet the most visible local impact of our larger hospitals often involves destroying low-income housing to build parking lots for suburban commuters. Our medical institutions have enormous potential to provide jobs to the neediest in their immediate communities, and not just custodial jobs. Aggressive recruitment and hiring, augmented with intensive training and advancement opportunities, could open the door to technical and professional positions by the thousands in each large city

and provide a valuable model for other employers. In each medical center we are now familiar with quality and expenditure monitoring down to the last suture. When will we add community impact to these indicators?

These issues add up to a challenging agenda for those concerned with the health of our urban patients, institutions, and communities. Both the APHA's Urban Health Committee and the Henry Ford Health System's Urban Health Care Symposium have brought together an impressive collection of highly skilled and motivated individuals who could influence national policy through careful analysis, advocacy, and demonstration projects. What we lack to date is an organization that would unite us and channel our energies and skills toward long-term goals. The time, however, is ripe. An Urban Caucus has emerged in the Congress, and the urban health crisis has reached page one of the newspapers and the evening television news. I believe we can look to the National Rural Health Association for a model of successful, informed advocacy. I hope each of you will consider joining a similar coalition on the *inside* of the suburban greenbelt, so that we can begin working on our larger vision as well as its pieces.

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