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Urban Health and the Social Contract: Poverty, Race, and Death

H. Jack Geiger, MD*

For more than three decades our nation has been concerned about a health care crisis; those three words are now almost a part of our national culture. The reasons for the prolonged and intense discussion on the health care crisis are well known, and there is no need to review them in great detail at the outset. We all have heard repeatedly about the inexorably rising share of the gross national product (GNP) that is consumed by the health care system. We all have heard about the millions of uninsured and underinsured. We know the staggering amounts of total health care spending: $604 billion in 1989, or $2,354 per person—40% greater than the per capita expenditure in Canada and double the mean of the 24 industrialized countries in the Organization for Economic Cooperation and Development. U.S. Budget Director Richard Darman estimates that, at the present rate, total public and private spending for health care will consume 17% of our GNP by the year 2000 and 37%—more than one-third of our total economy—by 2030 (1).

Cost is only one of the issues. We all have heard the stories of care curtailed or denied and of patients who have delayed even seeking care—something that happens 12 times more frequently among the poor and uninsured (2). We all know the consequences in morbidity and mortality.

Similarly, almost everyone by now is familiar with the usual roster of assigned villains: an open-ended insurance system with huge administrative costs and a nightmare of documentation requirements for patients and providers alike; the uninhibited introduction of new technologies, whether or not they are clearly beneficial or cost-effective; the increasing health burden of an aging population; acquired immunodeficiency syndrome (AIDS) and substance abuse epidemics; the maldistribution of health care resources; unrealistic expectations on the part of patients; malpractice suits; medical greed. The list is endless. There is ample evidence against each of the accused. For example, in a recent newspaper report (3) on the proliferation of hugely expensive magnetic resonance imaging machines owned by networks of physicians with a financial motivation to refer the maximum possible number of patients, the physician/investor in an imaging center in Atlanta was quoted as saying, "If there's more profit in it, what's wrong with that? ...This is an entrepreneurial society."

What is relatively more recent, after decades of this debate, is the emergence of *urban* health care as the most acute and dangerous component of the national crisis. Again, we tend to focus first on cost. The nation's 100 public hospitals, which are the only real form of "national health insurance" in metropolitan areas, have an average annual deficit of $9 million. Bad debts and charity care account for 42% of their charges, and 30% of their inpatient days and 52% of their outpatient visits are by uninsured patients (4). In Chicago, the *newest* public hospital bed was opened in 1925. Public hospitals are in critical condition, made worse by the inadequacy in coverage and in reimbursement rates of Medicaid, which also deprives the poor of access to private physicians.

In a Community Service Society study (5) of nine low-income minority communities in New York City, only 28 primary care physicians had hospital privileges and were fully accessible to the 1.7 million residents in those areas. One of the most deprived areas was central Harlem, which in 1985 had a death rate 87% higher than the New York City average. The study noted:

> "The main victims in Harlem are working age adults. Compared to New York City as a whole, the death rate for people aged 15-44 in Harlem was 240 percent higher; for those 44-65 of age, it was 128 percent higher. These were not deaths that arose from violence and drugs; the leading killers in Harlem were cancer, heart attack, hypertensive disease, pneumonia, diabetes, bronchitis. Not coincidentally, this is the same community that is documented here to have four fully functioning physicians to provide basic health care for its 214,000 inhabitants."

That survey included health districts with an infant mortality rate of 69.9 per 1,000 live births, about the same as Kenya's. For every infant death, approximately 100 babies are born with low birthweight, or addicted to drugs, or suffering from congenital anomalies or other conditions, many of them preventable.

The inner cities, in short, are islands of illness and premature death within the larger society, suffering epidemics of AIDS, tu-

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berculosis, hepatitis A, syphilis, gonorrhea, measles, complicated ear infections, and lung cancer. McCord and Freeman (6), whose survival analysis of age-adjusted mortality rates found that black men in Harlem are less likely to reach the age of 65 than men in Bangladesh, identified 53 other health districts in New York City—they called them "natural-disaster areas"—in which mortality rates for the < 65 age group were at least twice the expected rates. Death comes sooner—and after inadequate treatment—from cancer, heart disease, and diabetes. These are sentinel events, indicators not merely of the crumbling of the urban health care system but of larger changes in our society.

Before discussing those changes, I should note one factor that has remained distressingly constant: the rhetoric of reform. *JAMA* may devote an entire issue to a wide spectrum of proposals, ranging from the American Medical Association's own ideas to the proposals of the Physicians for a National Health Program, but political statements continue to be bland. Consider a recent comment by George Mitchell, the majority leader of the U.S. Senate: "The Congress and the Administration must provide leadership and insurance reform, cost containment strategies and expanded coverages for the poor and the elderly, for both the public and the private sector." But Daniel Greenberg, writing from Washington for a British medical journal (7), noted:

> "The rhetoric of crisis is intense, but the pressure for change is not focused. Meanwhile, the prospering health care industry is at the ramparts to protect its good fortune. The most informed, politically concerned elements of the population know about the failings of the system mainly from second-hand reports rather than personal experience... the despairing critiques of the health care system are familiar, and so is the likelihood that major reforms and access and cost containment will continue to prove elusive."

The long and dismal history of failure to introduce fundamental change, at least since the reforms of 1965, is one reason for some pessimism. There is, however, a deeper reason, and it constitutes my central theme.

I submit that any hope of truly reforming the American health care system is illusory without first, or at least simultaneously, effecting a fundamental change in our overall national social, economic, and racial policies, the set of understandings as to the responsibilities and limits of government that we call a social contract. I submit that we cannot, we will not, transform one part of that social contract in isolation from all the others, even a part as huge, as flawed, and as important as health care without confronting the need for broader social change. That, in turn, requires us to confront the barriers to such social change, to understand what has been happening to the social contract over the last 20 years, and how, in the main, that was accomplished. These recent changes comprise the most significant redefinition of the social contract since the innovations of the 1960s, which were in turn the biggest changes since the 1930s and the New Deal.

These changes of the 1980s—not the health care system per se—bear major responsibility for the desperate problems we now confront in the health status of many of our populations. These changes in the social contract have been documented in exquisite detail by the Congressional Budget Office and published by the House Committee on Ways and Means, and many of the following data on income shifts are drawn from that source (8). The changes of the 1980s include:

1. The redistribution of wealth upwards to those in the top 20% of family incomes, and within that group, most intensely, to the top 1%.

The inner cities are islands of illness and premature death within the larger society... Death comes sooner — and after inadequate treatment — from cancer, heart disease, and diabetes. These are sentinel events, indicators not merely of the crumbling of the urban health care system but of larger changes in our society.

2. The redistribution of both income and opportunity away from the middle class and the poor, an effort directed most intensely at the bottom 20%, those at or below 150% of the so-called poverty line.

3. The deliberate erosion—in some sectors, the destruction—of governmental responsibility and support for assistance in housing, education, nutrition, environmental protection, the creation of employment opportunities, and, not least, health care. In my own state of New York, for example, with its long record of innovation and leadership in the development of low-income public housing, only one project that might qualify for inclusion in that category is planned for 1992: the building of 3,000 new jail cells.

4. The virtual abandonment of federal support for cities, in direct proportion, I believe, to the concentrations of the poor and, above all, of blacks and Hispanics in urban centers, so that for a decade our cities have steadily and increasingly grown more black, brown, and broke.

5. The widespread acceptance of the belief that it is government itself, together with the poor and minorities themselves, that are the cause of our economic and social difficulties. Thus, those whom we once regarded as the victims of an inequitable society are now presented to us as the cause of inequity, especially as inequity is perceived by a struggling middle class. There has been constructed for us a new social entity, the "black underclass," in terms that emphasize personal behaviors (9) and ignore massive changes in the labor market and huge inequalities in educational spending, as a way of defining and explaining the growing class polarization of American society (10,11).

These changes—in both policies and beliefs—were the result of a sustained political effort, one that is ongoing still. The very core of that effort, I suggest, is the deliberate attempt to deepen the racial fault line that has always existed in American social, economic, and political life. We are told that our national difficulties are due to the behaviors of (and the special privileges allegedly afforded to) minorities, and that the only vestige of racism we now confront is affirmative action itself. (This in a na-

tion in which a 1990 survey conducted by the National Opinion Research Center [12] at the University of Chicago found that a majority of whites—on some questions, as high as 78%—believe blacks and Hispanics prefer welfare to hard work, tend to be lazy, are more prone to violence, less intelligent than whites, and are less patriotic!)

Let me present some statistics on some of the dimensions of these changes, drawn mostly from Congressional Budget Office data (which, for technical reasons, are substantially more accurate than Bureau of the Census analyses) and summarized recently by the Center on Budget and Policy Priorities (13):

From 1977 to 1988, the average *after-tax* income of the poorest fifth of households fell 10%, after adjusting for inflation.

The middle fifth of households experienced an average after-tax income gain of less than 4% over this period. The share of the national income going to the middle class—the 60% of U.S. households in the middle of the income spectrum—received 50.6% of all after-tax income in 1977; by 1988, its share had dropped to 46.3%.

By contrast, the top fifth of households realized an average gain in after-tax income of 34%. In 1988, the wealthiest one-fifth of the population received as much after-tax income as the other 80% of the population combined.

The Center on Budget and Policy Priorities also points out that the average after-tax income of the richest 1% of Americans more than doubled from 1977 to 1988, rising 122% after adjusting for inflation, from $203,000 in 1977 to $451,000 in 1988. In other words, the richest 1% (2.5 million Americans) now have nearly as much income as the bottom 40% combined (100 million Americans with the lowest incomes).

These changes, while due mainly to increased disparities in *before-tax* incomes, were exacerbated by changes in federal tax policies: since 1977, the richest Americans have received large tax reductions, while middle-income Americans have not. Between 1977 and 1992 (allowing for the impact of tax provisions in the 1991 budget agreement), the effective tax rate—that is, the percentage of income paid in all federal taxes combined—borne by the richest 1% will have declined by 18%. During this same period, the percentage of income that middle-income households pay in taxes is expected to increase from 19.5% to 19.7%.

Down at the economic bottom, something different was happening. In 1977, a family of four at the poverty line paid no federal income tax at all and also received a tax credit that offset most of their social security payroll taxes, so their combined income and tax liabilities came to only a little under 2% of their family income. By 1986, that same family was paying 10.5% of their income in income and payroll taxes, a sixfold increase.

From 1977 to 1990, the mean income of the poorest fifth of families fell by 14% in constant dollars. Some have argued that this is due to the changing composition of households in the bottom quintile, with a marked increase in the proportion of female-headed households and the elderly. However, data from the House Committee on Ways and Means (8) indicate that, while there have been some demographic shifts, 43% of the increase in poverty between 1979 and 1989 was due to reductions in benefit programs at federal, state, and local levels, especially cuts in Aid to Families with Dependent Children (AFDC) and in unemployment insurance.

Thus, from 1970 to 1991, the maximum AFDC benefit for a family of three with no other income declined 42% in the typical state, after adjusting for inflation. The average value of AFDC and food stamps *combined* has fallen to about the same level as the value of AFDC benefits *alone* in 1960, before the food stamp program was created. In 1972, a mother with two children who earned wages equal to 75% of the poverty line would have been eligible for some AFDC assistance in 49 states. In 1980, she would still have been eligible in 42 states. By 1990, her family could qualify for AFDC in only six states. The disposable income (including after-tax earnings, AFDC, food stamps, and the earned income credit) of a mother with two children who earned wages equal to 75% of the poverty line was $3,100 lower in 1990 than in 1972. In New York City, holding household composition constant, the poverty rate for female-headed households increased from 41% in 1969 to 63% in 1987 (14).

Overall, Congressional Budget Office statistics show that between 1979 and 1989, reductions in welfare programs like AFDC added 2.2 million people to the poverty rolls, while reductions in social insurance programs like unemployment insurance added nearly 1 million. Thus, during these years, the social safety net was being shredded and those at the bottom were falling through the gaping new holes. Almost every variety of public program was reduced, dismantled, or effectively limited in scope by draconian eligibility requirements. In Texas, for example, eligibility for Medicaid for a family of four is restricted to those with an income less than $2,200 per year, or about $1.50 a day per person for food, housing, clothing, and all the other costs of living (15).

It is these cuts, as much as reductions in health care funding per se, and combined with recession and unemployment, that have put the homeless out on the streets and the sick poor into the public hospital—or jail. The change in the social contract has created the conditions that so profoundly threaten the health of urban communities.

Any hope of truly reforming the American health care system is illusory without effecting a fundamental change in our overall national social, economic, and racial policies... We cannot, we will not, transform one part of that social contract in isolation from all the others, even a part as huge, as flawed, and as important as health care without confronting the need for broader social change.

The urban statistics on morbidity and mortality are frightening. Let me cite just one poignant example involving children.

The St. Louis Children's Hospital has reported a small epidemic (31 cases) of water intoxication—previously a rare condition—among poor infants over these last 15 years. All 31 infants lived in poverty and were fed excessive water; the most frequent reason was that their mothers ran low on formula and had to di-

lute it or substitute water. Most of the cases occurred in the last three years, a time when previously available free sources of formula disappeared (16).

I cannot help but contrast these patterns of redistribution with the one attempt at redistribution to the poor—and the minorities who are suffering most—that was offered recently by the current administration in Washington. The White House proposed to launch a new initiative against the highly visible and acutely embarrassing infant mortality rates in the inner cities—and to fund it by taking $54 million away from current community health center programs and maternal and child health block grants, major existing sources of protection against infant mortality for the urban poor and the less visible rural areas. In other words, it is wrong to redistribute income but not to redistribute death.

Race is used as an issue to divide populations that in reality have common interests and common suffering. Only one of ten poor children in 1989 was black and living in a female-headed household on welfare in a major city. More poor children live outside than inside big cities, and nearly two-thirds of all poor families have only one or two children. Also, a majority of poor families with children had at least one worker and a paycheck, not a welfare check, as the family's largest source of income. Poverty is not race-blind, but neither is it race-specific, and it does not match the stereotypic images presented to us repeatedly by the media.

Race is frequently raised as an issue and coupled with an attack on the *old* social contract. President Bush, in a recent speech, said the Great Society programs of the 1960s, the embodiment of a social contract invoking government responsibility, had discouraged individuals from becoming good workers, that the crusade against poverty had backfired, that civil rights programs had "generated animosity," and that welfare programs had made poor people dependent on government. The charge of failure, for obvious reasons, omitted any reference to the following hugely beneficial and successful programs embodying that social contract: federal aid to elementary and secondary schools, Headstart, the Voting Rights Act of 1965, the Fair Housing Act of 1968, Medicare for the elderly and Medicaid for the poor, the nationwide food stamp program, environmental laws, and the network of community health centers. Instead, the President suggested a "good society" in which individuals perform private acts of common decency and become "points of light." That social contract is called *noblesse oblige*, and it has left us with 10,000 new points of blight.

What has happened to us, as a nation, to account for this great change in our social orientation? One of the most perceptive and eloquent statements has come not from a political commentator but from a playwright and dramatist. Steven Tussich (17) wrote:

> "We are fleeing, as we have for decades, from the unfulfilled pledge that we are 'one nation, under God, with liberty and justice for all.' The hopeless despair of our millions, the third-world poverty in the heart of our cities, the resulting tidal wave of crime, this social rot at our very heart, have become as dangerous as any nuclear waste dump. Lacking the resolve to confront these problems, we are fleeing from them in all directions: to the suburbs, to cities and other parts of the country, to other countries, to other wars.
>
> "But we have been doing this for a long time. The social diseases of racism, poverty, drug addiction and crime, never fully addressed, were allowed to fester or grow... the problems that took generations of neglect to create require the patient dedication of generations to undo. But we have become a nation that no longer seems to have the will, the vision or the deep-seated conviction to measure its endeavors by generations...
>
> "During the '80s, in a very violent way, the rich got richer, and in an even more violent way, the poor got poorer... We have now become that most worrisome of super-powers: isolationists in regard to problems at home and interventionists in regard to the problems of other nations... We have come to rely on external enemies for comfort and confirmation of our identity as a people."

And then, of course, we can claim that we are Number One. It should be no surprise, then, as Dr. Seth Foldy (18) pointed out at Henry Ford Hospital's first Urban Health Care Symposium, that we are first in the world in narcotics addiction, first in handgun homicides, seventh in spending on public education, and 18th in reducing infant mortality. I would add another item: we are first in the world in the percent of our adult population in prison, surpassing even South Africa.

Pessimism—and the picture I have drawn of the task that confronts us is a gloomy one—is nevertheless no reason for inaction. Let me offer, therefore, a modest suggestion for one health care reform and one account of a basis for optimism.

The community health center movement was one of the important innovations of the 1960s in both urban and rural health care for the poor. Numerous, careful studies in the 1970s demonstrated that such centers provided high-quality, accessible, and comprehensive care, lowered hospitalization rates and emergency room use, improved health status, and were highly cost-effective (19-22). There is a proposal in draft legislation in the Congress to quadruple their number—now approximately 600 nationwide, serving some 6 million low-income people—over the next five years. The earlier studies strongly suggest that the costs of this expansion would be repaid rapidly in reduced hospitalization, in the reduction of the present burdens on both public and voluntary hospitals, in reduced infant mortality and disability rates, in increased immunization, and in early and effective treatment for substance abuse.

However, there is a limitation: the desperate shortage of health personnel, especially physicians, willing to work in the inner city and in such settings. Community health centers are already close to crippled by personnel shortages. The latter-day structure of the National Health Service Corps and all of the quid-pro-quo state programs will still provide a scholarship or a loan to pay medical school tuitions on the promise that the recipients will "pay back" with several years of service in medically underserved areas. But there is always a buy-out. In New York, at least, with three such separate programs, the results are almost uniform: about 20% of all those in medical school who have received such help eventually work in underserved areas; 50% to

60% buy out—go to the bank with their MD degrees and their residency requirements completed and negotiate a loan to repay the penalty for refusing such service. Another 20% to 30% are simply lost to follow-up. The system just does not work.

The reasons are not just economic. I believe many physicians and other health personnel feel that by working in community health centers and other institutions in the inner city, they would be out of the mainstream of medicine, marginalized in low-status jobs in difficult circumstances without social or professional support.

There is a resource that we have not tapped: the professional societies—the American College of Physicians, the American Academy of Family Practice, the American College of Obstetricians and Gynecologists, and the like. They could contribute to solving this problem by creating a category of special and real—not merely honorary—public service fellowship status for graduating residents who choose to serve in inner cities and rural poverty areas. Such service could accrue special credit toward fellowship status in those professional societies. The societies could undertake to provide ongoing educational and other support—senior mentors, advice on simple health care and clinical series research, and participation in annual meetings for the usual two- or three-year duration of service.

Ultimately, my contention is that we need a public interest/public sector medical school in many of our major cities, uniting public universities, public hospitals, and health departments. Conventional medical education, with the best will in the world, is not interested in or committed to this kind of service. We need schools capable of providing special training appropriate to the needs and problems of the urban and rural poor, just as we have a Uniformed Services Medical School that provides special training for the needs of the military.

Such schools could draw upon the vast reservoir of untapped human resources in the very populations we aim to serve. The medical school at which I teach, for example, usually has 25% to 35% black and Hispanic students. Most of the student body come from low-income families; many are the first in their families to go to college, let alone medical school. Indeed, social class may be more important than ethnicity: we are creating the first working-class medical school since the Flexner Report.

Recognizing these untapped resources has much to do with how we think about the poor and with what the poor think about themselves: the expectations they mount and the beliefs they hold about their futures. We are most often taught that the poor and their communities, rural or urban, are sinkholes of pathology. The pathology is real, but these communities are also reservoirs of enormous (and unacknowledged) strength, resilience, and ability. We need an epidemiology of strengths, not merely of pathologies, to recognize that.

I first became convinced of the reality of this reservoir of strength when I worked with colleagues in rural Mississippi, in what was then the third poorest county in the United States, in a health center that served a target area of some 500 square miles, with a population of 14,000 blacks and several thousand poor whites, with an annual family income (in 1966) of less than $900 per year, with a median educational level of fifth or sixth grade in miserably poor schools. As part of the health center program, we launched a modest educational enterprise, taught by the center's professional staff at night: a high school equivalency certificate program, and a college preparatory program for those who had a more complete education. We opened a small office of education at the health center to help end the isolation of this population from other institutions and to help them apply to colleges and professional schools and for financial aid—resources that had been kept from these people by the prevailing social structure for many years.

In the first decade, from this poor county and the few surrounding counties very much like it, that effort produced seven black physicians, five black PhDs, one person who has just completed a term as a state mental health commissioner, two full professors at prestigious universities, more than 20 registered nurses, about a dozen social workers, and the first 12 black registered sanitarians in Mississippi's history. One young woman, a sharecropper's daughter with a ninth-grade education and six children who joined our staff as a trainer of aides at age 26, now holds my former job as Executive Director of the health center—and she has a doctorate in social work and has put all of her children through college. These data and anecdotes are a measure of the potential that exists in the populations we serve.

The community health center movement was one of the important innovations of the 1960s in both urban and rural health care for the poor. There is a proposal in draft legislation in the Congress to quadruple their number over the next five years. The costs of this expansion would be repaid rapidly in reduced hospitalization, in the reduction of the present burdens on both public and voluntary hospitals, in reduced infant mortality and disability rates, in increased immunization, and in early and effective treatment for substance abuse.

My argument, then, is that we have to do more than repair the health care system. We have to confront head-on the maldistributions I have described. We have to work to redefine the social contract yet again. This is not an argument to postpone health care reform until these larger tasks are accomplished; on the contrary, we must try to use health care reform as an explicit and deliberate tool for reform in the social contract.

Our task is illustrated by a true story, an experience that I found deeply moving. It serves as a metaphor for the attempts we have to undertake. In 1957, when I was a third-year medical student at the then Western Reserve University, I seized the opportunity to go to what seemed to be the best department of social medicine then in the world—of all places, in South Africa, at the one medical school then open to nonwhites. The department ran two comprehensive teaching community health centers, one in a periurban African township near Durban, and the other in what was then called a rural Zulu tribal reserve of about 500 square miles. I worked in both centers, and the experience changed my life. These were the models for the first two community health centers my colleagues and I later launched in the

United States, at the Columbia Point Housing Project in Boston and in Mound Bayou, Mississippi.

A few years later, under Grand Apartheid, the South African centers were closed. Ten years later, the great social epidemiologist John Cassel, who had worked at Polela, the rural center, returned to see if there were any identifiable residual effects. He found only one: a continuing and increased level of educational aspiration and achievement in the population served by the health center.

A few years ago, in connection with some of the work of the Committee for Health in Southern Africa, physicians from South Africa and from the African National Congress (ANC), in exile, came to an international workshop in New York. There I met Dr. Nkosasane Zuma, an ANC physician exiled in London. I asked her where in South Africa she was born. "Polela," she said, and ultimately we calculated that she had been a child when I was there as a medical student. I asked her if it was true that the Polela health center had such an impact on educational aspiration.

"Oh, yes," she said. "In the first generation, many people got educated and some were professionally trained as doctors and teachers and lawyers. In the next generation—mine—people got educated but also became politically militant and active. But this was true only for part of the tribal reserve. It happened if you were close to the health center, saw the role models, saw the interactions among people of different races, saw what education meant in the lives of people. But you also had to live in the part of the reserve that was near the highway."

That made no sense. "Why is that?" I asked. She said, "Because you really had to understand that there was a road out."

It seems to me that our task is to join with the people we serve in finding, creating, and demonstrating that there is a road out of poverty, rural or urban, a road out of racism, a road out of inequity, a change in the society that could follow in part from change in the health care system but without which such change will not take place. There is no more challenging or moving opportunity in our work.

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