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The problems of urban health care are diverse and representative of the United States health care system. Our current system of delivering health care is a network of different programs, facilities, and institutions. The characteristics of local health care systems vary among regions and between rural and urban areas. Urban health systems share certain attributes and face similar problems such as budget deficits and dealing with the rise in drug abuse and the spread of the acquired immunodeficiency syndrome (AIDS). These pressures contribute to the problems of increasing health care costs and the declining access to health care.

These shortcomings in the U.S. health care system are especially evident when compared to other countries. The United States has the most advanced medical capabilities of any country in the world. Life expectancy in the United States ranks near the average of all developed countries. The only other developed country that does not provide universal access to its citizens is South Africa. Our country spends at least 3% more of the gross national product on health care than any other country in the world. The rate of infant mortality in America is consistently among the highest in the developed world and ranks significantly higher than that of Singapore and Hong Kong.

These overall statistics about health in the United States point out some problems but also hide many other issues. For example, many of these statistics do not reflect the much worse health status and reduced life expectancy of our country's disadvantaged groups. The life expectancy of blacks is more than 6 years less than that for whites. Furthermore, while life expectancy for whites has been increasing, the life expectancy for blacks has decreased in recent years. This is partially due to increasing urban violence, but the net result was a lower life expectancy for blacks in 1988 than in 1982. Another trend within the United States that has recently taken a turn for the worse is the rate of childhood immunization. A survey of measles vaccination rates in eight inner-city populations revealed that between 19% and 49% of children had not been vaccinated by their second birthday (1).

The Squeeze on Health Systems by the Federal Deficit and the National Economy

The disparities in health status and the shortcomings of the U.S. health care system could be improved—if only we had unlimited resources. There are many worthwhile activities to spend more money on. However, the children of the 1990s have inherited a large "credit card bill" in the form of a $3 trillion national debt. The result is that almost $1 of every $7 in the federal budget goes toward paying the *interest* on this debt. Although this is not directly a health issue, it does hinder the nation's ability to redirect resources toward improving health. To compound this problem, newly identified urban health issues such as environmental lead and maintenance of sanitation systems need to be addressed. We cannot allow the infrastructure of our urban health systems to become deficient. We can learn from the lessons of other countries here, too: the cholera outbreak in South America is the consequence of allowing urban sanitation systems to become substandard and of the public's eroding awareness of hygiene.

Fortunately, in Michigan and in the United States, our problems are not as severe as those in South America and other parts of the world. Yet, as a society, we are facing our own problems. AIDS, drug abuse, the uninsured, the economic downturn, and the rising costs of health care all are taking their toll on the ability of urban health systems to function.

Federal Support of Urban Health: Infrastructure and Personnel Needs

The problems of urban health care have not been lost in the Washington bureaucracy. Federal support for urban hospitals is unquestionably necessary because of the increasing pressures of delivering health care in an urban setting. For example, hospital charity care, Medicaid underpayments, and bad debts have increased steadily throughout the 1980s.

Congress has continued to support important components of federal programs for urban health care centers. These include: 1) Medicare provisions to support hospitals that care for a disproportionate share of Medicaid and indigent patients ($1.04 billion in 1990); 2) Medicare payments to teaching hospitals to assist with the increased costs of providing health care in a training

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environment ($4.2 billion in 1990); 3) federal support through the National Health Service Corps for physicians to work in underserved areas ($39 million in 1990); and 4) federal support to the cities hardest hit by the AIDS pandemic was formalized by the Ryan White CARE Act. This program will provide relief to some of the hardest hit urban areas, including $1.8 million for Michigan for part of 1991, with the possibility of another $300,000 by the end of the year (personal communication, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Management and Budget).

National Health Care Reform

The problems of our health care delivery system are receiving a considerable amount of attention in Washington. The discussions in the offices, halls, dining rooms, and streets of Congress are marked by many areas of agreement about this issue, but many areas of disagreement remain. There is agreement that the cost of the U.S. health care system is a problem and should be a priority for reform. However, when specific methods of reform are discussed, there is little agreement. Should we switch to a Canadian-style system? Should change be evolutionary or revolutionary? How will we finance any changes? What changes can be made to control costs in the future?

These and other questions are integral to the debate about how to shape the future of health care in the United States. Another issue that permeates these discussions is how to ensure that the changes will not degrade the quality of our current system and result in less access to health care for any groups.

Because the urban areas are already subject to great stresses, they would be vulnerable to adverse effects of health care reform. Similarly, they are also situated to receive the benefits of health care reform. In addition to controlling health care costs, reform of the health care system will help to stabilize funding for health care systems. Under the current system, cities are subject to local and regional variations that can curtail funding for health care. A more uniform system of health care delivery and financing would eliminate disparities between the health care systems of different employers and areas.

Another benefit of reform would be to control the rapidly rising price of health care. Controlling health care inflation would be beneficial for the economy and help international competitiveness. For example, health care adds about $400 to the cost of manufacturing each automobile in the United States as compared to the cost in Japan. According to information provided by the Chrysler Corporation, health care costs per vehicle in 1988 were: $700 in the United States (includes employee and retiree premiums, Medicare payroll taxes, workers' compensation medical costs, and imputed supplier health care costs); $375 in France (includes payroll taxes and imputed supplier health care costs); $337 in Germany (includes payroll taxes and imputed supplier health care costs; $246 in Japan (includes payroll taxes and imputed supplier health care costs); and $223 in Canada (includes payroll taxes and imputed supplier health care costs and excludes general tax payments).

Because of the many problems with the current system and the potential benefits of reform, there is movement toward consensus. A group of Democratic and Republican Representatives and Senators convened a commission to develop a strategy for health care reform. This group, initially known as the U.S. Bipartisan Commission on Comprehensive Health Care, was renamed the Pepper Commission after its original chairman Claude Pepper, a Congressman from Florida. The recommendations issued in the final report of the Pepper Commission in September 1990 have been useful in the discussion of health care reform and also have generated two legislative proposals in Congress—one by Senator Rockefeller and one by Congressman Waxman. The Commission's report also spawned the Senate Democratic Leadership bill recently introduced by Senate Majority Leader George Mitchell. The Democrats in the House of Representatives also are currently working on a proposal.

Because these are serious and complicated issues, agreement on the exact path for health care reform is not clear. However, extensive discussion on the issue of health care is expected to surface in the 1992 Presidential campaigns, and this may help to focus the debate. In the meantime, there will continue to be discussions about what is desirable, conceivable, and politically possible. From the perspective of the elected official, this is an extremely important issue, because any action will have consequences for all segments of society.

Health Care as a Community, Family, and Personal Issue

One issue that is frequently forgotten in health care reform debates is the crucial role of the states and local communities in the actual delivery of health care. A great strength of the United States is its diversity of people, cultures, and environments. This diversity also makes it difficult to centrally direct national programs. Thus, it is important that these programs be flexible so that they can be directed towards local needs.

The problems of health care delivery extend to the local neighborhood, family, and even personal levels. No two communities are the same. Differences in local industries can create different environmental health hazards. Different ethnic groups have different predispositions for chronic diseases. Various cultures place different emphasis on maintaining good health and seeking health care. This diversity creates the need for community involvement in the decisions that affect their health care systems.

The individual and the family are in the best position to safeguard and improve their own health. One way to improve health is to prevent illness and injury from occurring. Prevention of many health problems can only realistically be accomplished by individuals because they are predominantly affected by personal life-style choices such as diet, alcohol use, and smoking. In addition to ensuring access to health care, the government has a responsibility to ensure that information about proper health practices is provided to all citizens.

Congress is beginning to integrate these preventive concepts into federal health programs, because they will not only improve health but may save money as well. We have made some progress with prevention, but we need to do even more, not only in the traditional health setting but also in other areas that affect

overall health, such as housing, agriculture, and the environment.

Because health care is an issue that affects everyone, all sectors of society must become involved in and informed about the problems and potential solutions. This will simultaneously engage everyone in the discussion about health care reform and educate the public about maintaining their own health. For nurses, pharmacists, physicians, and all other health professionals, this means communicating with their patients and communities about what the problems are and what the individual's role can be. For the individual, this means taking steps to become aware of the issues, to preserve personal and family health, and to convey his/her concerns and perspectives to elected officials. For local elected officials, this means regional cooperation to help solve some problems. For those of us in Congress, this means reaching out, listening to the people we represent, and understanding what the problems are at the individual, family, and community levels. It also means ensuring that the current health care system receives the resources it requires to continue functioning and that we continue to explore measures to improve the health of our nation, whether it be through revolutionary or incremental changes.

Reference

1. Measles vaccination levels among selected groups of preschool-aged children—United States. MMWR 1991;40:36-9.