a new attack on an old problem

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PERHAPS THE MOST IMPORTANT single point to remember in any discussion of health care for the disadvantaged is that they are a remarkably varied group. Many disadvantaged live in areas that are traditionally underserved—the crowded inner city, the Indian reservation, and the remote, depressed rural area. However, it is difficult if not impossible to pin them down to a racial, ethnic, geographic, or even economic

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identity. For example, women—by no means a generally poverty-stricken group—are often disadvantaged in access to health careers, if not to health care.

Health Care and Career Problems

Data from the National Center for Health Statistics show that disadvantage, as it applies to health care, is frequently a function of low income. A 1971 survey of total days of bed disability (days per year in which a person is confined to bed by illness or injury) shows a national average of 6.1 days per year. Persons from families with incomes of less than $3,000 per year had 12.6 days of bed disability per year—more than double the national rate—and persons from families in the $3,000–$5,000 income range had 8.4 days (*1*).

Disadvantage, then, as used in this discussion, refers to factors or combinations of factors which tend to make access to health care or to careers in the health care field difficult. It is an oversimplification to stamp nonwhites, as by definition, disadvantaged. While geographic or economic conditions may be a powerful impetus toward disadvantage, these factors are not so for all persons. There are many reliable statistics which show that nonwhite people as a group tend to be disadvantaged, but it is clear that poor whites in Appalachia and elsewhere are medically underserved and, by any objective standard, badly disadvantaged.

In the two decades between 1950 and 1969, according to the National Vital Statistics Survey conducted by NCHS, some reduction occurred in excess mortality for nonwhite people in the United States. But for most age groups large mortality differentials still persisted for 1969. In fact, nonwhite males actually lost ground; in 1969 they had greater excess mortality over white males than they did in 1960 (*2*).

The National Health Survey reported that while 38.9 percent of the black parents surveyed described the health of their 6- to 11-year-old children as very good, 53.8 percent of the white parents so described their children's health (*3*).

Frequently, the health status of nonwhites shows improvement over time, but fails to equal the still greater improvement registered by whites. For example, the infant mortality rate for nonwhites dipped from 83.7 per 1,000 births in 1935 to 29.0 in 1972. But during the same years, the white infant mortality rate decreased from 51.9 to 16.3 per 1,000. A 40-year-old white man in 1971 could expect to live another 32.1 years. A nonwhite man of the same age could expect to die nearly 4 years sooner (*4*).

Similarly, nonwhites have more debilitating diseases, higher maternal death rates, and less protection through immunization from infectious diseases than whites. Yet, when we look beyond racial division, we may only conclude that—as studies of rural-urban disadvantage have shown—the city dweller of whatever race is often better off than his rural counterpart.

Infant mortality is higher among the rural poor than among the least-privileged urban group. Rural residents, especially the elderly, are more likely than urban dwellers to have disabling chronic ailments. Compared with urbanites, rural residents are more likely to have higher rates of injury and more workdays lost as a result of illness or injury. Also, relatively more rural than urban residents have never seen a physician. Access to health care for rural Americans is limited by a multiplicity of factors: lower income levels, a higher percentage of elderly people, lower education levels, and general shortage of medical manpower (*5*). The American Medical Association has estimated that rural residents have only about half the access to health resources as is available to the rest of the country's population (*6*).

The picture shown by the number of disadvan-

taged persons in professional and paraprofessional health careers is no more reassuring, as the following statistics derived from the 1970 census illustrate. Although 11 percent of the population was black in 1970, only 2.2 percent of the nation's physicians were black. Of the approximately 12 million persons of Spanish heritage in the United States, about 10,300 or 3.7 percent were physicians (*7a*). Of the more than 800,000 Native Americans, about 50 were physicians, according to the American Association of Indian Physicians. Women also are notably underrepresented in the health professions, with the exception of nursing. In 1970, only 3.4 percent of the U.S. dentists and 9.2 percent of the physicians were women (*7b*).

Although considerable progress has been made in recent years in opening up opportunities in the health fields to minority groups and to women, much still remains to be done before these groups reach roughly the same proportion in health professions and occupations as they are in the general population of the United States. In medical schools, the first-year enrollment of black students rose from 2.7 percent in academic year 1968–69 to 7.2 percent of the total in 1973–74 (*7c*). First-year enrollment of women in health-profession schools also increased in recent years, indicating the progress that has been made in attracting more women into the health professions. In medical schools, first-year enrollment of women rose from 9.0 percent of total first-year enrollment in academic year 1968–69 to 19.7 percent of the total in 1973–74 (*7d*).

There are other problems which affect adversely the ability of the health care industry to render care to certain groups of people. It is notable, for example, that the American Medical Association in 1972 identified no less than 140 counties in 26 States, with a combined population of nearly a half million people, in which no resident physician was active in patient care. These counties are centered mainly in the southern and western States, and include 14 counties in Georgia and Nebraska, 16 in Missouri, 15 in South Dakota, and 25 in Texas (*8*).

Thanks to the Southern Regional Council, we can look closer still at this problem of maldistribution to discover what it can mean to the poor people who are so frequently its victims. In Tennessee, for example, in 1971 there was an average of 1,055 people per physician. In metropolitan counties, there were 712 people per physician, and in rural counties of the State there were 2,471 persons per physician. Yet, even in urban areas extreme shortages cropped up. In Chattanooga, before the opening of an inner-city neighborhood health center only 2 physicians out of a total of 300 in the city were residing within and serving the eventual target area of the center—an area populated by more than 30,000 people (*6*).

In some areas of New York, there is but 1 private physician for every 12,000 residents. Many black ghettos show ratios of 1 physician for every 3,000 to 10,000 residents. One medical office building in an upper middle class section of Chicago has more physicians than has the entire west side ghetto, with a population of 300,000. Few physicians or allied health personnel are available to Chicanos living in urban barrios in such places as East Los Angeles, Calif., and Albuquerque, N.Mex. (*9*).

With all these factors in mind, it becomes possible to define the disadvantaged. They can be seen as all those people who, because of race, sex, age, economic status, formal education, or geographic location, experience inequities in access to optimal health career opportunities.

The single factors of race or sex or income group are not in themselves seen as causing a person to be disadvantaged. But a combination of such factors can greatly predispose people in the direction of disadvantage, and it also can greatly affect the capability of this nation to furnish high-quality medical care to a considerable number of its people. Yet, Chairman Paul Rogers of the House of Representatives Subcommittee on Health has accurately stated, "The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government" (*10*).

Steps Toward Alleviation

To even begin to address that priority, we face at least a threefold job in the alleviation of the health problems of disadvantaged people.

- We must collect and develop data, much of which exist, if at all, in widely scattered locations. After a decade of emphasis on the needs of disadvantaged groups, large gaps remain in the information we must have if we are to sustain a broad attack on those needs. In addition, we must have evaluative instruments so that we can measure with confidence the impact of innovative programs on disadvantaged populations.

• We need to pioneer new models, plans, and ideas which may lead to the improvement of health status in our target groups, including the testing of new models of innovative health care and of manpower programs which can be shown to aid disadvantaged people in relation to health problems.

• We must furnish a focal point within the health industry for efforts to extend the scope, quality, and effectiveness of programs to serve the disadvantaged. This function includes assisting other Government and private groups in improvement of their programs.

There is also a continuing need to enhance the disadvantaged consumer's understanding of when and how to use the health care system. And we must deal with extremely delicate problems involving personal pride and human dignity, which may be as crucial to obtaining care as the more mundane issue of how to purchase it.

OHRO grants and contracts. To address these problems at the Federal level, the Office of Health Resources Opportunity (OHRO) has been established in the Health Resources Administration. Currently, OHRO has two financial tools at hand with which to address itself to the health care and career problems of the disadvantaged. In fiscal year 1974 we awarded 22 contracts and, through the 10 DHEW Regional Offices, some 65 Special Health Career Opportunity Grants (SHCOG) amounting to more than $12.5 million. These awards are being used to demonstrate ways in which to encourage disadvantaged persons to move into training and jobs in the health care field and to improve the access of the disadvantaged to health care.

Under one contract, we supported efforts of the American Public Health Association to attract more minority group members and poor people to its October 1974 meeting in New Orleans, where problems of the disadvantaged were high on the agenda.

In the mountains of eastern Kentucky, the Kentucky Youth Research Center, Inc., is attempting to furnish a model for the utilization of different techniques and manpower to bring greatly needed dental care to poverty-stricken children. Fourth- and fifth-year dental students are working as dental manpower extenders, and the project is training dental assistants for service in the general area. Community based treatment of communications disorders will be made available, and the project will train speech and hearing aides to provide therapy and screening in speech, vision, hearing, and dental needs. In addition, health education and disease prevention materials will be distributed to needy families.

Still another contract is focusing on the problems of women in the health care industry. Being carried out by the Radcliffe Institute in Boston, the project is collecting all existing employment information on women in the health care system. Coming out of the study will be a document, "An Analysis of Women in the Health Care Industry in the U.S.," and recommendations for constructive programs to support the employment of women.

A number of contractors are working with children of minority group background seeking to identify, inform, motivate, and counsel such youngsters about the advantages of health careers. These programs affect Native American children in Oklahoma, Florida, and California and black children in Louisiana.

The contract program will be extended to a point when, by the end of this decade, OHRO will be supporting as many as 80 contract projects —both new and continuation—all seeking to provide models of techniques useful in improving the access to health care for the disadvantaged. Several additional important contract projects in these areas are currently being administered by other Federal health programs.

The SHCOG program is a continuing effort to bring the disadvantaged population into contact with health careers. SHCOG supports projects designed to recruit into the health professions and other related fields disadvantaged students—especially members of minority groups—women, and students likely to practice in disadvantaged areas. The health professions included are medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, and veterinary medicine.

Grants are awarded for projects which will identify and enroll in health-profession schools persons whose backgrounds and interests make it likely that they will practice in disadvantaged areas. Grants are awarded also for projects which will identify disadvantaged students with potential for health training, enroll them in health schools, and assist them in completing training.

By themselves these grant and contract programs are a hopeful start, and their scheduled expansion in the years ahead will be a long stride forward. But of themselves they are not enough to attain the goal projected by the Student National Medical Association of 12 percent minority representation in the medical schools of the nation by 1975.

Future goals. During the remainder of this decade, we have an ambitious agenda. If we can complete the following goals, we will be in a far more solid position from which to bring about the equity we seek.

- We must determine through studies and surveys, as appropriate, whether health professionals from disadvantaged groups do in fact provide more, less, or the same medical services to disadvantaged people than do health professionals from nondisadvantaged groups, and we have to document those facts statistically.
- We will have to identify and promote those factors which have the greatest effect in motivating people to enter the health manpower pool.
- Similarly, we need to know what special retention efforts may be needed to retain a disadvantaged person after he has entered the pool.
- We need to identify the manpower, facilities, supplies, and support services necessary to provide primary medical care to the disadvantaged.
- With the increasing likelihood of equalized financing mechanisms through some sort of a national health insurance system, we still do not know enough about what these will do to improve access to and use of health care for the disadvantaged. We have to find out in order to protect the obvious interest of the disadvantaged.

The foregoing goals cannot be attained independently. We are establishing working relationships both in and out of Government with agencies equipped with the resources to assist in carrying them out.

The problems of the disadvantaged seeking equitable health care are stubborn and difficult, but we do not believe that they are intractable. It is our hope that we are in the kind of catalytic position needed to move on these problems and find solutions for some of them. At the very least, it is a job worth trying.

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