THE FUTURE OF HEALTH SERVICES FOR THE POOR

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THREE YEARS AGO Dr. George James observed that "poverty is the third leading cause of death in New York City." Dr. James was in a position to know—he was the city's health commissioner. His statement was intended to jolt the complacent, and it did.

The shock wave was strong because the statement was true. Poverty never appears on a death certificate. But it takes its toll: through failures in preventive medicine, fatal delays in seeking treatment, care that is inaccessible or inadequate, poor nutrition, congested living, and in many other ways that make disease more likely to happen, less likely to be checked, more likely to kill.

Throughout most of human history, and throughout much of the world today, poverty has been not the third, but the first, cause of death. It is the mark of an affluent society when heart disease and cancer claim more victims than the diseases directly associated with want and misery.

Yet even for us, in our own time, affluence is only an outer shell. Beneath it are the hard facts of poverty's toll as a disabler and a killer.

In the United States today, nearly one out of every three persons in families with incomes under $2,000 per year suffers from a chronic condition that limits his activity; for families with incomes above $7,000, the figure is one in 13.

In the United States today, men in the age-range 45 to 64, the years of top productivity, average 50 days of disability per year among families with incomes under $2,000; for the over $7,000 income group, the figure is 14.3 disability days.

Those who are poor go to the hospital more often. They remain longer—an average of 10.2 days per hospital stay for the under $2,000 group as contrasted with 7.2 days for the group above $7,000. This is true despite the self-evident fact that they are less able to pay, less likely to have insurance which covers the bill.

Another set of statistics tells a similar tragic story. The contrasting mortality and morbidity rates of our white and nonwhite populations confirm the inequality of health services.

A white baby born today can expect a life-span of 70.2 years, while a nonwhite baby has a life expectancy of 63.4 years—10 percent of a lifetime less. Four times as many nonwhite mothers die in childbirth. Twice as many nonwhite babies die in infancy.

When we turn the spotlight on specific diseases, we see further confirmation. Influenza and pneumonia take more than twice as high a toll among the nonwhite population. Tuberculosis—the great scourge of our grandparents' generation—is all but forgotten except among the poor and nonwhite. Venereal disease is now largely concentrated in the core of our great cities. Nearly all the remaining cases of diseases that need no longer occur at all—typhoid, diphtheria, poliomyelitis, and others—strike those who live in poverty.

Indeed, it would be possible to prepare a set of overlays of a map of the United States. One would indicate areas of high incidence of venereal disease, another of tuberculosis, another of high infant and maternal death rates, another of excessive disability rates from chronic disease. These overlays would cover almost identical territory. And that territory would coincide with another set showing where the poor are congregated—in inner cities and isolated rural areas. The shadow of poverty and the shadow of avoidable disease and early death are the same shadow. They beshroud the same land and the same people.

This fact is more than a national tragedy. It is a national reproach. It is more than unfortunate; it is unconscionable.

President Johnson has said:

"Good health services are the right of every citizen, not the privilege of a few. No American should be denied the opportunity for good health care because he lives in a sparsely populated area or deep in the slums of a large city, because he is unemployed or underprivileged, because he is one of poverty's young or very old, because he lacks access to doctors, hospitals, or nursing homes, because he does not know where to find or how to use health services, or because his affliction extends beyond our present knowledge and our current discoveries."

He has also said, in a Special Message to the Congress, that we must aspire to "good health for every citizen, up to the limits of this country's capacity to provide it."

The President believes, and I believe, that this country's capacity is very high indeed. But cold statistical truths as enumerated show how very far below capacity we are performing for a great many of our citizens.

Barriers to Health Care

What are the barriers that separate the poor from the health care that they need and that medical science is capable of providing them? What are the obstacles that we, as a society, must tear down?

First, there are barriers of accessibility. For a variety of reasons, good health care is difficult or impossible to obtain for many of our urban and rural poor.

One such barrier is based on actual shortages. As a nation we do not have enough physicians, enough dentists, enough nurses, enough supporting manpower, and enough hospital and nursing home beds to meet the needs of our people. These shortages affect everyone, regardless of socioeconomic status, to a greater or lesser extent.

Photograph by Steve Larson

Vice President Hubert H. Humphrey visits a Denver Neighborhood Health Center. While parents receive medical attention, youngsters crayon in the nursery.

For the poor the extent is greater, because of the barrier of maldistribution of the resources we have. In a study of the Watts area of Los Angeles, Dr. Milton Roemer found that 106 of the 251,000 people living in the district surveyed were physicians—a ratio about one-third that for Los Angeles County as a whole. Of these physicians only five were board-certified specialists. Two of the eight small hospitals in the district were approved by the Joint Commission on Accreditation; for most hospital services the people living in the district were dependent on Los Angeles County General, 10 miles and an hour's bus ride away.

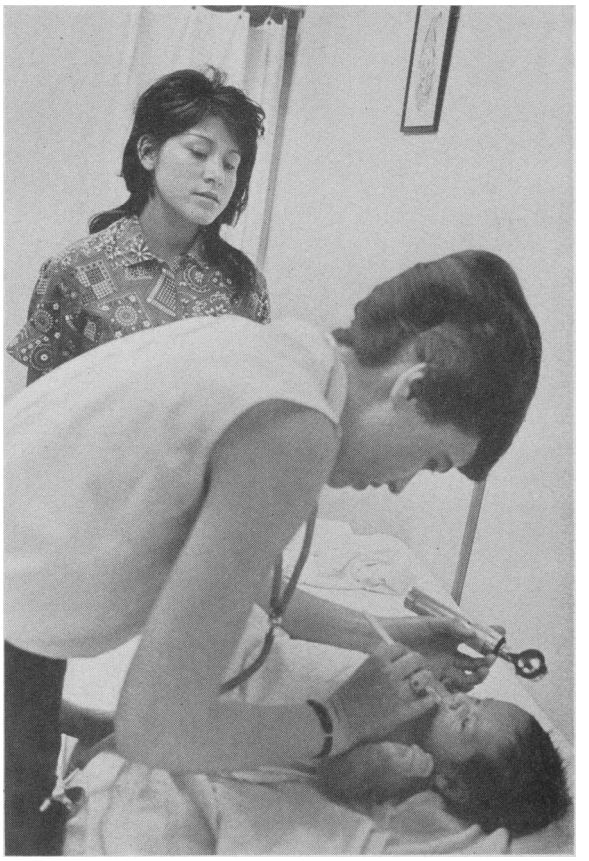
Counterparts of these conditions can be found in almost every major city. For the rural poor, the distribution pattern is likely to be even more unfavorable.

Meanwhile, among nonwhites, the rate of recruitment and education of potential physicians and dentists is still dismally low. Students in low-income families are not entering medical and dental schools at anything like the rates necessary to do justice to their own professional interest or to the patients of all races whom they might serve after graduation.

Another barrier is cost of health service.

The price of medical and hospital care is rising faster than any other component of our economy. The advance of private health insurance over the past few years has benefited millions of Americans but few of the poor who are in most urgent need of help. The great legislative advances of Medicare and Medicaid are helping to lift the burden of cost from the shoulders of the aged and medically indigent, but we cannot delude ourselves that the cost barrier has been eliminated.

Finally, there is the problem of not knowing where to turn. Health services for the poor are fragmented and dispersed. Even those that exist are not easy to find. The individual who needs health care has to shop around for it. And, as Surgeon General William Stewart recently pointed out, "Among all the goods and services he purchases, health care is perhaps the most difficult for him to shop for intelligently. The Yellow Pages are of limited help and there is no Consumer's Guide. . . . The price tag is never displayed. . . . He usually has a very vague understanding of the kind of service he needs and a very inadequate basis for judging the quality of service he receives."



Photograph by Steve Larson

Nurse Mary Alexander examines a baby as the mother watches at a Denver Neighborhood Health Center.

Elsewhere, Dr. Stewart has said, "Today the individual gets to the right place at the right time largely by happenstance. Many do not."

Thus, there are numerous barriers that place good health care beyond the convenient reach of the poor. And in addition to these barriers of accessibility, there are also barriers of acceptability.

For the care that our poor people receive leaves a great deal to be desired, even after they have run the obstacle course to obtain it. Dr. Kenneth Clement of Cleveland, in his keynote address at the recent centennial conference of the Howard University College of Medicine, described indigent medical care as seen through the eyes of those who receive it.

"It is delivered in ways that are depersonalized and lacking in continuity. There is no

one health professional with whom the family can build a trusted relationship.

"It is fragmented care—if sick, go here; to be immunized, go there; if a specialty problem, go somewhere else.

"The care is rendered without care for the family as a unit. . . .

"It is often inaccessible. . . .

"The institutions are often distant from the poverty areas. . . . The inaccessibility is often increased by the failure of institutions to provide hours that do not require the patient to miss employment—and employment often without sick-time benefits."

Dr. Clement summed it up this way:

"The patient must often wait long hours at overcrowded clinics in public or voluntary hospitals, and is not infrequently told to return on some other day when those responsible for manning the clinics are not available. His desire for privacy is consistently ignored and his dignity in many ways degraded."

This is not a pleasant portrait of the health services received by one in almost every five Americans. It is a portrait of at least partial failure—by health departments, private medicine, hospitals, medical schools, voluntary agencies. There is plenty of failure to go around.

What is being done to make health care both accessible and acceptable to those who need it most? The answer today is not enough. Not nearly enough.

Making Health Care Accessible

Yet it can be said that here and there we are beginning to face the problem squarely—as the single greatest challenge confronting our total medical resource. Federal, State, and local agencies, the voluntary health movement, the medical schools, and the medical profession itself are starting to experiment, to try out new ways of reaching the unreached.

Dr. Ellis Sox of San Francisco, president of the U.S. Conference of City Health Officers, reported this past June on one small but significant example of what can be done. For several years, about 25 percent of all appointments at the San Francisco Chest Clinic had not been kept by tuberculosis patients—a loss of treatment dangerous not only to the patients but potentially to the whole community. It was found that four neighborhoods—differing ethnically and culturally but having the common denominator of poverty—accounted for most of the missed appointments.

Accordingly, decentralized chest clinics were set up in three of the neighborhoods distant from the central facility. A team functioned in each district two half days a week. Within a year the proportion of missed visits had dropped to 6.6 percent. Now the rate is 2 percent. It dropped below 1 percent in a Chinese neighborhood when clinic hours were set in the afternoon to accommodate people who tended to be late risers. Little things count. Human things count.

At the Federal level we estimate that fiscal year 1968 expenditures for Federal grants and payments for health care for the poor will be about $4 billion. The largest share of this amount—some $2.8 billion—represents vendor medical payments under title XIX and health insurance for the aged under title XVIII of the Social Security Act.

These funds can literally make the difference between life and death, and between health and misery, for countless Americans. But they won't help unless the service is there for the people to buy. If these legislative advances are to be translated into health advances, we need to redesign the systems by which care is delivered.

At least a part of the remainder of the $4 billion Federal investment has this redesign as its central purpose. New approaches are being simulated. They are beginnings. But in them one can see the future strategies of health care for the poor taking shape.

A key element of the War on Poverty being led by the Office of Economic Opportunity is its comprehensive health services program authorized by the Economic Opportunity Amendments of 1966. The intent is simple and of enormous importance: to provide dignified personal health services to low-income families, readily accessible to them, with the greatest possible participation in each program by the poor themselves.

The geographic base of this program is not the region or the State or even the community as a whole, but the neighborhood. The object is to put the services where the people live. But this is not the whole story. For this program is designed to attack the full cycle of poverty and

disease. Neighborhood people are being trained to serve in the health enterprise as community health aides and in other capacities. Health needs manpower and poor people need jobs; this program puts these two needs together.

In the very short period of this program to date, 41 neighborhood health centers have been funded. Those already in operation are proving that the concept works. Local residents are taking them to heart and participating enthusiastically in their activities. People are getting comprehensive and continuous personal health care that would have been far beyond their reach. They like it, and they want more.

So far, of course, these 41 centers represent only a small drop in an ocean of need. But they are generating tremendous attention. More than 300 communities have already expressed interest in joining the program. It is estimated 600 or more would be needed to reach those who could use their services.

Fortunately in other programs of the War Against Poverty—Project Head Start, Job Corps, Work Experience and Training—medical and dental attention are helping to reduce the massive backlog of disease, disability, and defects.

The Children's Bureau of the U.S. Department of Health, Education, and Welfare sponsors a program aimed specifically at the needs of mothers, children, and youth in poverty areas. Federal grants have helped to initiate nearly 100 projects—two-thirds of them providing maternity and infant care and one-third giving services for children and youth. Preliminary data indicate that these are already having an impact on high infant mortality rates. Many of these projects are logical nuclei around which comprehensive care programs for entire families can be built.

Another program well underway is serving another group of deprived Americans far from the heart of the cities—the American Indians and Alaska Natives. Since 1955 the Public Health Service has been carrying out a full-scale medical care program for these 380,000 heirs of a tragic chapter in the American past. During this period infant mortality among the Indians has dropped 45 percent, and there have been similarly impressive declines in maternal mortality, incidence of tuberculosis, and other diseases. Nevertheless, disease and death rates for American Indians remain well above those for the general population. As in the OEO program, training and employment as health aides and sanitarians is an important part of the Public Health Service effort.

Our domestic migrant agricultural workers are benefiting from Public Health Service project grants which help to pay for family health service clinics and other health services including direct medical care, preventive medicine, nursing and sanitation services, and education in health and nutrition. Selected migrants are being trained as health aides.

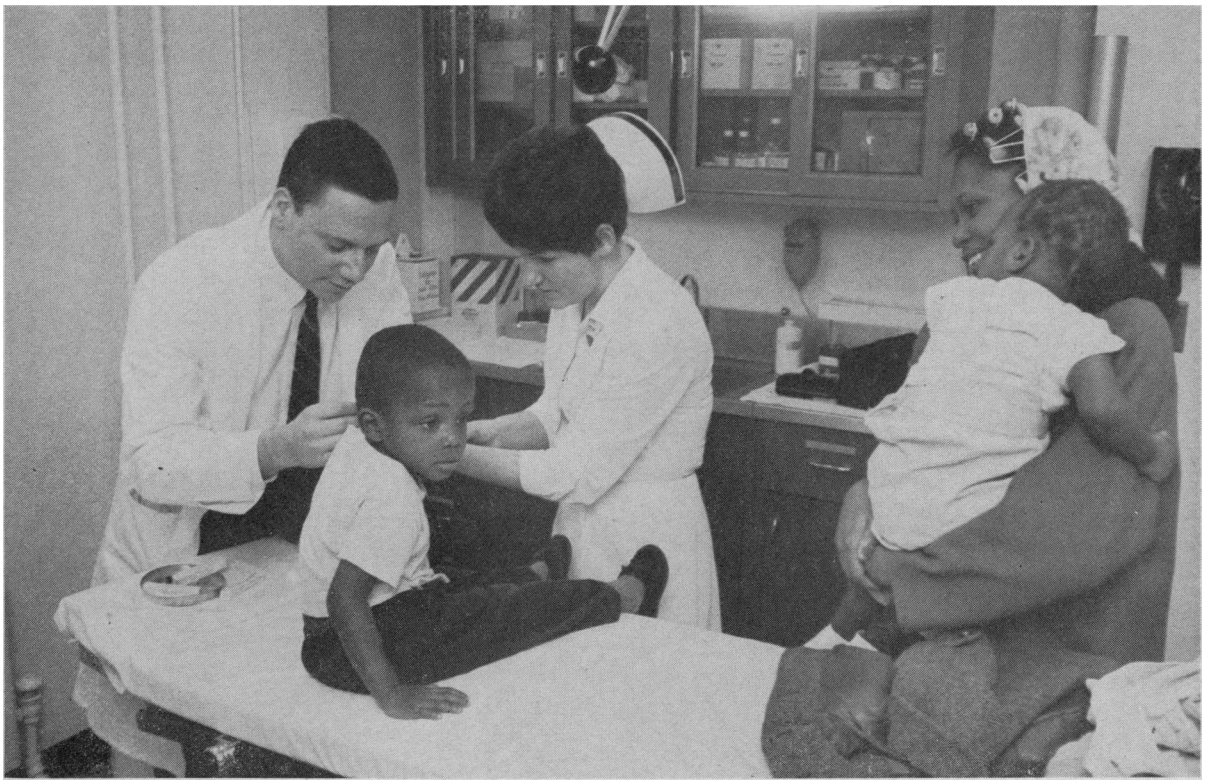
In the critically important and long neglected field of mental illness, community mental health centers are bringing treatment out of isolation in vast, remote institutions and into the community setting. Recently the National Institute of Mental Health has established two centers for research, training, and services directly related to mental illness problems among the poor and the human and behavioral aspects of poverty.

An impressive project is underway involving collaboration between the Appalachian Regional Commission, OEO, HEW, the State health department and University of Kentucky, and private groups including the United Presbyterian Church. The aim of this alliance is to bring health services within reach of the rural poor in Appalachia through demonstration and planning projects. A likely starting point is the 49-county area of eastern Kentucky where 57 percent of all families live on less than $3,000 per year and where health services have been all but nonexistent.

These few samples serve to illustrate a new awareness, a new drive to strike at the root of the health problems of the poor. They are innovative. They are happening where the people and the problems are. They are involving the people themselves in the solution of their own problems.

New Strategies

Most important, they foreshadow a future which will require additional bold new strategies, new incentives, new commitments on a large scale by all our health resources. Let me



Photograph by Paul Conklin

Family health care at Columbia Point Center in Boston includes vaccine for a small boy.

sketch out a few of these strategies that are now taking shape and suggest others that should follow.

The first is a new strategy of health care for the poor.

This new strategy will require a sharp break with obsolete patterns and emphases. The accent must be on mobility and flexibility, on ambulatory rather than rigid institutional care. We need to put our services where the need is—out where the people live. The neighborhood health centers now in operation point the way—but we cannot afford to rest until medical resources are reasonably accessible to every city neighborhood and every area of rural isolation. And we cannot afford to stop experimenting with new approaches and techniques.

Moreover, we need to link neighborhood centers with the great medical institutions where the most complex care can be delivered. Fleets of station wagons and mobile units may be as important an investment as a new hospital wing. The person needing care must have access to the course of treatment he needs, wherever it may lead.

Carrying out this new strategy will require a major commitment. The governmental and nongovernmental health forces of the nation must decide that here is where the action is, where the priority is placed. Health resources are limited. Inevitably there is competition among many worthwhile projects for the use of resources. The needs of the poor must be given primacy in this competition until the tragic gaps are closed. In the words of the National Advisory Commission on Health Manpower in its recent report, "Programs for health care of the disadvantaged should be given highest priority and made available wherever needed."

The new strategy of health care for the poor will require new patterns of training for health manpower. Today, as Surgeon General Stewart has pointed out, the young physician is increasingly oriented to the university and hospital with "tidy, well organized, and sterilized surroundings," which are the antithesis of the cha-

otic environment of the poor. Accordingly, "his ability to understand the health needs of people in their social context tends to diminish. He doesn't speak their language any better than they speak his."

In short, our professional schools must turn outward into the community, become involved with its needs, and prepare their graduates to serve there. At the same time there must be a major effort, on a large scale, to develop and use the talents of those who live in poverty areas to the fullest extent in helping to meet their own problems. It is inexcusable that health should be an island of manpower shortage in a sea of men and women seeking useful work.

Expanded recruitment of local manpower will help to crack the communication barrier. People talk to their neighbors, and the word gets around. But there are other tasks to be done in the communications field as well. We can make much more imaginative use of television—a much more universal medium among the poor than any form of the printed word.

Both commercial and educational television have only begun to fulfill their respective responsibilities in health education. Dull programs beamed at any time, particularly in hours of low viewing, are hardly the answer. The poor do listen to radio, too. Stations which know how to attract sizable audiences to "the top 40" tunes ought to be able to tell the story of the top 10 disease killers.

Other resources which can be invaluable are voluntary health organizations. They have served many Americans in low-income brackets, but their presence in the inner city is only rarely felt. There, it would be hard to find their educational pamphlets telling how to recognize symptoms; their audiovisuals are little seen; their casefinding or patient-service is relatively infrequent.

Voluntary organizations—or for that matter—official units cannot easily reach out to the poor from offices miles away; a branch in a neighborhood store front or a display in a local church building can help do the job much more effectively. Every means of direct contact should be utilized. Where the poor have telephones, they should be called by understanding voices, preferably those who "speak their own language." Where there are no phones, friendly volunteers can knock on doors. The poor need to know that services do exist for them, that disease is not "inevitable" or beyond remedy. A pregnant mother needs to be asked by someone she trusts to be sure to come in for prenatal care. An alcoholic needs to be urged by someone who understands his problem to seek out help. Can anyone estimate the heartbreak suffered by epileptics and their families because of inaccessible counsel and inadequate care?

Whether a problem requires medical or paramedical help, whether it is obvious or subtle, potentially serious or a lesser blight, someone who cares should take it up with the patient or his family. Absence of timely help and special skills can be tragic. The lack of a speech therapist can consign to a lifetime of needless disability boys or girls with a stutter or stammer.

Many of the poor, including the young, have multiple handicaps. A Mongoloid child, for example, needs not only medical attention, but special education and a variety of other professional services if he or she is to realize personal potential.

As chairman of the President's Council on Youth Opportunity, I am determined that the young should have access to timely help of all kinds, especially medicine.

Linked to this new strategy of comprehensive interdisciplinary personal health care, there must be a massive new strategy of preventive medicine. Diseases that need not happen must not happen. Diseases that can be detected and cured in early stages must not be allowed to run their course.

Poliomyelitis is almost gone from this country. But there have been two outbreaks in recent years. One was in a low-income housing project in an eastern city. The other was among Mexican-Americans along our southwestern border. Both testify to breakdowns in delivery of health services where the needs are greatest. Poliomyelitis will be eradicated in this country; measles will be eradicated; and within a few years German measles with its terrible toll in unborn babies can be eradicated—but not until our vaccines reach every corner of the land.

Similarly we can sharply reduce the toll of cancer and heart disease and other killers and

cripplers by applying mass multiphasic screening, using refined automation fully and effectively.

Chronic disease strikes rich and poor alike. But among the poor it kills or disables many who might be spared. Cervical cancer kills poor women because, three decades after the Pap smear test was developed, they still do not receive the benefits of this simple procedure. This need not happen. We have the technology to stop it. All we lack is the decision to apply it—not as a separate and isolated effort but as an integral part of our health services system, neighborhood by neighborhood.

A third prong of our attack must consist of a new strategy of environmental change. The urban poor live in surroundings where smog hangs heavy, where refuse collects in the streets, where rats run, where plumbing fails. These substandard conditions of the physical environment are intolerable in a nation like ours.

Further, there is a second dimension to the challenge of building a healthy environment. The social climate of the poor, with its noise and congestion, its ugliness and hopelessness, its fear and frustration, aggravates conditions which breed mental illness, narcotic abuse, alcoholism, homicide, and suicide. These are epidemic diseases that cry out for full-scale effort, not by the health partnership alone but by all the forces of society that can help facilitate a better life.

This is the key. The war on poverty is total war. Poverty and disease, ignorance and unemployment form a cycle that is self-perpetuating and self-accelerating. No total solution is possible for a single segment of the problem. But by the same token, success against any salient weakens the whole.

Therefore, above all, we must pull together. In the Federal Government many agencies in many departments are engaged in this effort. OEO, HUD, Agriculture, Labor, and every component of HEW are deeply committed, not only to achieve success in their separate endeavors but also to achieve a total impact that is greater than the sum of the parts.

But the Federal effort is only a beginning. It needs strong allies to reach into the streets and alleys and mountain hollows where the problems are, where the people live, where the action must take place.

We need, and we seek, a true voluntary partnership across the nation. In the health field, a major new legislative instrument has been designed for this purpose.

A Flexible Partnership for Health

The Partnership for Health Program under Public Law 89–749, the Comprehensive Health Planning Act, is based on the principle that planning and action for health can best be done as close to the people as possible—in the States and communities. This program underwrites State and local planning. It provides wide flexibility for the use of Federal grant funds to meet locally determined priorities and needs. It wagers high stakes on local initiative and local decision. And the Surgeon General has already stated that in administering the program top priority will be given to projects promising delivery of better care to the poor.

Secretary John Gardner has recently summarized this new approach to the challenges that face us.

"As we look more systematically at the tasks ahead, we are finding that we must free our thinking from time-worn categories. The problems won't stay in the old pigeonholes. They aren't Federal or State or local; they are all three. They don't respect State or municipal boundaries. They refuse to stay in the limits of long-established fields such as vocational education or health or housing.

"So we're learning to follow the problems where they lead. We look at a whole system—a metropolitan area, a regional watershed, or to take a very different kind of example, the system for delivery of health services. We look at poverty in all of its aspects with all of its roots and all of its consequences."

To strike at those roots, to reverse those consequences must be the aim of future health services for the poor. In doing so we seek to reweave the total fabric of health care in this country so that its unquestioned excellence extends to all our people. To do this we need new commitments, new incentives, new assessments of priority. We need new strategies that will mobilize our health professions, our great voluntary

associations, our universities and research institutions, and our governmental agencies in a common cause.

Patchwork improvements simply will not do. Routinely pouring in increasing amounts of public money to obsolete, overburdened, underefficient or inefficient resources makes for neither good economics nor good medicine.

Our goal is the most modern system that free men can develop cooperatively to serve not just the poor but all Americans. As the Advisory Commission on Health Manpower observes: "Innovations introduced experimentally for the care of the disadvantaged should be carefully examined for their applicability to the care of all persons. Conversely, programs for the care of the disadvantaged should incorporate elements from existing methods of medical care, wherever appropriate."

In its Declaration of Purpose for the Comprehensive Health Planning Act, the 89th Congress declared ". . . that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living. . . ."

Everyone who has walked in the ways of poverty knows how far removed we are from this high aspiration. Let us dedicate ourselves to a future of health services for the poor that will fulfill the national purpose by permitting fulfillment of every man, woman, and child in America.