THE URBAN POOR AND HEALTH CARE REFORM
ACP Statement of Principles, February 1994

Many inner cities have a legacy of socioeconomic ills and medical underservice that have resulted in extraordinarily poor health indices for their populations. Within the present debate over health system reform, we see the opportunity to change this legacy, as well as the danger that these problems will not receive adequate attention because of their magnitude and complexity. Although the underserved areas of urban America face many of the same problems as rural underserved areas, in this statement we focus on the particular needs of inner-city populations and the elements of health system reform that can meet these needs. Disproportionate numbers of minorities, uninsured and low income citizens and non-citizens characterize the inner city.

1. A reformed health system should achieve universal coverage for health care and access to effective, appropriate quality care.

True health care reform must include universal coverage to eliminate financial barriers to care. As the first priority, universal coverage must be assured and implemented at the initiation of a reformed system. Instead of receiving ongoing care and preventive services, individuals left uncovered are likely to require crisis care in emergency settings, which is costly and far less likely to improve overall health status. Coverage and care for undocumented individuals would be a major health care and financial burden for many urban areas if not provided and supported by the reformed health system.

Inner-city populations have impaired access to care because of non-financial factors, such as insufficient numbers and kinds of providers, transportation, language barriers, and cultural differences. These factors must be addressed as well. In a new system with universal coverage, health plans have financial incentives to enroll such populations (thereby collecting premiums) without actually delivering care. This must be prevented.

For insured groups facing significant non-financial barriers to care, all health plans must conduct outreach programs that include enabling services—i.e., those that increase the capacity of individuals to utilize health services. Outreach programs must be documented, and regulatory mechanisms must be developed to counter the financial incentive to cover people without enabling them to gain access to care. In addition, cultural differences should be studied and more fully understood in order to deliver care that is culturally sensitive and appropriate to different populations groups.

2. A reformed health system should provide a benefit package that is broad and inclusive. Special funding must be available for public health and categorical programs that target specific community health problems.

The health status of inner-city populations is extraordinarily poor. They suffer from higher death rates and shortened life expectancy; higher infant mortality rates; higher incidence and prevalence of almost all diseases, including heart disease, cancer, stroke, diabetes, HIV/AIDS, sexually transmitted diseases, alcoholism, substance abuse and tuberculosis; and a higher incidence of violence-related injuries. These needs demand a broad benefit package that is appropriate for all, particularly the most vulnerable populations.

The benefit package should address the special needs of inner-city, vulnerable populations. Limits on
coverage for mental illness, long-term care and dental care would have particularly detrimental effects on the urban poor, who do not have personal resources or alternatives to obtain care outside the system.

Existing preventive and public health initiatives should be integrated into a reformed health care system. Categorical programs that target major community health problems must be maintained and expanded. Examples include maternal and child health programs, services for people with HIV or tuberculosis, and programs based in community health centers and schools. Funding should be available for coordination and synergy between practitioners and the public health system.

3. A reformed health system should ensure an adequate number and mix of providers in the inner city.

It is well-recognized that this country has a geographic and specialty maldistribution of physicians. Too few physicians choose primary care specialties, and too few choose to practice in rural and inner-city areas. Increasingly, these areas face a dearth of non-physician providers as well. A variety of strategies have been proposed to address these workforce issues, including retraining subspecialist physicians, mandating that a higher percentage of medical school graduates train in primary care specialties, and increasing the use of non-physician providers. All strategies should be based on careful, data-based planning and should build in flexibility to address regional and local health needs.

Inner-city areas have been plagued with a lack of primary care practitioners and institutions. Too often this has resulted in delayed care or episodic care in emergency rooms. Our present educational system does not produce enough graduates (both primary care and specialist) who are willing to work in the inner city. In this case, there is a mismatch between the products of our educational programs and the needs of society. To compound this problem, the fact that reimbursement is insufficient to support inner-city practices is sending the wrong message to young physicians. A change in educational philosophy and practice is needed. Undergraduate and graduate medical education should, wherever possible, feature and nurture experiences and training in health care for the underserved urban poor. Trainees should have the chance to interact with role models who deliver care in inner-city community settings. For this to happen, inner-city primary care providers and teachers must be fully integrated into academic centers, with formal appointments and privileges, opportunities for faculty development, and linkages back to the medical schools for continuing education and research. Academic health centers in the inner city should adapt and receive support to provide these resources.

A multifaceted approach is needed to ensure an adequate physician workforce for the inner city. Medical schools should recruit more applicants likely to practice in underserved urban areas and provide students with well-planned and managed educational experiences in these settings. Medical schools should foster student initiatives to work with vulnerable populations in community settings. Medical institutions should work with community groups to develop and expand health care training sites. Financial incentives, including scholarship programs (such as the NHSC), loan paybacks and tax credits, must be used to encourage practitioners to locate in inner-city areas and to stay there. Non-physician providers, working in a system for which physicians are responsible, should help with the provision of primary care.

4. A reformed health system should support "safety net" institutions which already deliver care in areas of great hardship, presently with limited funds and facilities.

Community health centers, public hospitals, and some academic institutions have extensive responsibilities for delivery of care to the inner-city poor, uninsured and underinsured. These facilities have the
historical mandate to care for all the sick, regardless of financial status, and they have done so despite inadequate resources. Even in a reformed health system, these providers would care for people who are left without insurance, either by design or by accident. This would include undocumented persons if they are not covered.

The unusually high costs of providing care to individuals with complex illnesses in difficult circumstances must be subsidized to avoid continuing financial losses, and to make these institutions viable and competitive in a reformed setting. Adequate financing for such institutions should not be compromised, either during a phase-in period of reforms or as a final result. These providers are particularly vulnerable to reductions in Medicaid funds, loss of disproportionate share funding, uncompensated care for undocumented persons, inadequate provision of transition funding to replace reduced numbers of postgraduate trainees providing care in hospitals, and inadequate risk adjustment methodology.

5. To address the root causes of poor health in the inner cities, improved health care must be coordinated with community revitalization efforts, both public and private. Coalition-building and coordination among community organizations, civic groups and health care providers will be the most effective strategy in tackling health problems.

The health of a community is inextricably linked to its socioeconomic circumstances. Factors contributing to ill-health and poor outcomes in the inner city include: poverty, joblessness, inadequate housing, violence, substance abuse, as well as lack of access to medical care. Health system reform alone cannot address these basic problems.

Our inner cities must be revitalized through an infusion of public and private investment. Community groups must be at the center of these revitalization efforts, working in tandem with businesses, banks and health care providers and academic health centers. Existing programs should be analyzed for their effectiveness, and successful ones should be updated, enhanced and widely publicized. Existing organizations and governmental offices have experience setting up a structure for community coalitions, and they should be used and nurtured.

6. A reformed health system should overcome the disincentives to capital investment in inner-city health services.

Inner-city areas have disincentives to capital investment including: the wealth deficit in urban areas that prohibit them from capitalizing new health investments; deficits in past capital investment that degraded the health infrastructure in these communities; deficits in primary care providers to serve these communities; longstanding deficits in health care and social investment that have led to high rates of acute and chronic morbidity, which make these communities unattractive for investment by cost-conscious health care organizations even if premiums are available.

Unless the health care infrastructure is rebuilt, inner-city populations will be left with diminished access to quality services, and inner-city providers and institutions will remain non-competitive in a reformed system. Inner-city populations will remain relegated to a second tier of care that does not match the quality and availability of suburban counterparts.

To overcome the disincentives to capital investment in inner cities, there should be significant and assured subsidies to businesses and organizations that provide health care. In addition, public funds should be used to upgrade facilities to the point where they become attractive for capital investment.
A reformed health system should have mechanisms to monitor overall access to and quality of care, especially for the most vulnerable populations, such as the inner-city poor. The medical profession should be responsible for monitoring and maintaining the quality of the care provided.

The history of attempts to provide coverage and deliver care to the inner-city poor proves the need for quality assurance mechanisms. These mechanisms must operate on two levels: on a systemic level, to ensure access and prevent abuse by insurers or providers, and on a clinical level, to ensure that the care provided is appropriate and necessary. On both levels, quality should be monitored continuously. Quality assurance is a process that must be based on valid research, statistical data, and good information about what works and what does not.

The following systemic mechanisms should be in place: special accommodations to enroll the inner-city poor, with safeguards against enrollment abuse; special efforts to inform people about their choices; guaranteed access for the inner-city poor to purchasing cooperatives or health alliances; incentives for plans to enroll the sickest patients; regulations to ensure that health alliances and health plans are responsive to community needs; and fail-safe provisions to ensure that global budgets do not mean that quality is sacrificed.