THE MISSING VOICE: IMPACTS OF HEALTH SYSTEM CHANGE ON LOW-INCOME COMMUNITIES

DAVID R. JONES, ESQ.

ABSTRACT Unique problems in obtaining adequate health care face poor urban communities. These include the rising number of uninsured, abuses in the managed-care system, the unwillingness of private providers to deliver health care for either Medicaid recipients or the uninsured, and an insufficient supply of primary care physicians in minority neighborhoods. If the managed-care system is to bring decent health care to poor urban communities, it must avoid the mistakes of the past. The health care system must be community based, oriented toward primary care, sufficiently funded, and universally accessible. There needs to be better coordination between medical schools and community health requirements and better support for public health facilities. Without adequate health care for the poor, urban living will eventually become more onerous for all.

In its 150-year history, the Community Service Society and its predecessor agencies have worked to help the poor of New York City. We launched the drive for pure milk laws, set up a tuberculosis treatment program in Harlem, and helped establish children's health clinics. For decades, we have fought to improve standards for the immigrant poor. The Community Service Society and many others triumphed: public health measures had a dramatic impact on the health status of the poorest New Yorkers. Now, there are signs of sliding backward, however. Urban health care delivery is one of the areas of great concern.

To address the unique needs and problems facing poor urban communities in obtaining adequate health care, we should focus on several important matters that have accompanied the conversion of the health care delivery system to managed care.

Mr. Jones is President, Community Service Society of New York, and a former Member of the Board, Health and Hospitals Corporation, 105 East 22nd Street, New York, NY 10010.

GROWTH IN NUMBER OF UNINSURED

The number of uninsured people nationwide reached 40 million in 1997. It is expected to grow at the pace of 1 million a year. Of New York City residents under age 65, 25% do not have health insurance.

Federal, state, and local welfare policies will inevitably add to their numbers: 420,000 New Yorkers will be forced off the welfare rolls over the next five years. Most jobs available to those coming off welfare do not provide health benefits, yet Medicaid is guaranteed for only the first six months. Fewer poor people are eligible for Medicaid, and obtaining that coverage has become much more confusing.

It is estimated that 125,000 new immigrants arrive in New York City each year. The latest legislative maneuvers have left most of these immigrants ineligible for Medicaid. This not only adds to the number of uninsured in the city, but also increases the pressure on an already overworked public health system.

Medicaid coverage of poor families in New York City has declined from an average of 68.2% in the decade between 1985 and 1995 to a low of 60.6% in 1996. Fully 40% of the city's poor children live in families that receive no public assistance and no Medicaid benefits.

Because of the inflation of health care costs, the working poor who are members of managed-care organizations now face significant increases in premiums, further squeezing meager paychecks. This, too, will add to the growing numbers of the uninsured. These families have to make the choice between the basic needs of shelter, food, and clothing and health care insurance.

The plight of the uninsured poor is perhaps best exemplified by a recent case brought to me by my social work staff. A legal immigrant suffering from a gunshot wound was turned away from a prominent Manhattan voluntary hospital because he did not have medical insurance. His wound was bandaged, and he was sent—with the bullet still in his hand—to a public health facility. If this example of "health care" for the uninsured is typical, the poor have reason to worry.

I do not mean to imply that this hospital was malevolent or shirked its responsibility. The financial implications of providing potentially costly care to those without insurance can be devastating to hospitals struggling with reduced revenues because of the increasingly competitive health care climate. This is not the failure of an individual hospital, but rather of a health care system that has not found a way to pay for services for all.

Our own public health system has an extraordinary challenge. Its mandate

is to serve anyone without regard to ability to pay—both legal and illegal immigrants, the poor, and those without health insurance. We cannot expect voluntary hospitals to provide care without compensation. This is the reason the facilities of the Health and Hospitals Corporation exist.

DETERIORATION OF THE HEALTH CARE DELIVERY SYSTEM

The deterioration of delivery systems is most noticeable in poor urban communities. When I was growing up in Bedford-Stuyvesant over 30 years ago, urban minority neighborhoods relied on the local family doctor for their health care needs. Many of these doctors were locked into their communities because of discrimination, which barred them from access to the best medical schools, denied them hospital admitting privileges, and prevented them from setting up practice freely. Nevertheless, they were an integral resource in my neighborhood.

Fast forward to today. For all practical purposes, local doctors in private primary care practice no longer exist in minority and poor communities. Some of this is an inadvertent result of earlier policy decisions. In the 1970s, Medicaid mills sprouted to take advantage of generous reimbursements. To combat this abuse, a cap of \$11 to \$13 was put on the fees that private physicians could charge Medicaid patients, while hospital-based rates were allowed to rise with inflation and beyond.

Not surprisingly, physicians began to refuse to accept Medicaid, and new physicians realized they could not establish a viable practice in neighborhoods with high concentrations of Medicaid patients. With the civil rights movement of the 1960s and 1970s opening up enormous opportunities for minority physicians, an out-migration of the few minority physicians left took place. Thus, there was an increasing reliance on hospital-based care, an unanticipated and unintended consequence of a legitimate policy objective.

If the inadequate supply of physicians were not enough, another important factor in the health care crisis for New York City's poor is the declining ability or unwillingness of private providers to deliver health care to the poor. It is not only the increasing number of people without health insurance who will find themselves unable to obtain needed health care.

The costs of health care are outrunning Medicaid rates, discouraging physicians from taking on Medicaid recipients as patients. In 1997, the state health commissioner acknowledged that Medicaid managed-care rates have not kept up with costs and raised the capitation rate throughout the state. Nonetheless, the inadequacy in the rates has caused private managed care to opt out of poorer communities. A recent example is the retreat by a well-known health maintenance organization (HMO) from building an ambulatory care facility in central Brooklyn.

Several years ago, the Community Service Society conducted a study of the availability of primary care physicians in some of New York City's poorest neighborhoods. We found a graphic demonstration of the abysmal health care situation in African American and Latino communities.

In central Harlem, 1 fully functioning physician—who was board certified in a primary care specialty, who had admitting privileges at a nearby hospital, and who accepted Medicaid patients—existed for every 53,500 residents. It is not surprising that many people in these communities rely on hospital emergency departments to receive routine medical care.

The near absence of doctors in minority neighborhoods persists. Managed care has not reversed the exodus of minority doctors from these areas because Medicaid rates do not keep pace with costs. The common wisdom is that the market will correct this problem, but there is no evidence that market forces are expanding capacity in poor, medically underserved neighborhoods.

Nor are we training the right kinds of doctors. A recent report by the Association of American Medical Colleges confirmed that minority graduates are more likely to enter primary care and are four times more likely to practice in socioeconomically deprived neighborhoods.

We have a number of world-class medical schools in New York City that train large numbers of doctors, but minorities comprise only 11% of the current medical students in New York State, the lowest percentage since 1991. While the need for more physicians dedicated to urban health care is increasing, the supply is decreasing.

The attacks on affirmative action are making a difficult situation worse. The number of minority graduates of medical schools is already inadequate, and now two of the states with very large medical school enrollments and large numbers of under-represented minorities—California and Texas—have abandoned affirmative action programs, substantially cutting minority access to medical education.

Most medical schools, both directly and indirectly, receive millions of dollars every year in public money. This is in the form of tax exemptions for medical schools and hospitals, direct subsidies, and other supports to medical students. Graduate medical education receives even more direct subsidies through Medicare and Medicaid reimbursements. Given their reliance on public funds, medical schools should do a better job of recruiting students dedicated to health care in the urban environment by working with local colleges to nurture students through the rigors of undergraduate preparation and medical school.

This new world of managed care does not need more superspecialists; what it needs is primary care providers who can connect to the individuals and

communities they serve. Having providers who are “culturally sensitive” to the needs of poor communities, because they grew up there and because they know those communities intimately, is more critical than ever if our goal is to reach people earlier and encourage preventive care, early interventions, healthier lifestyles, and a coordinated, truly managed health care system.

**FAILURE OF MANAGED CARE TO ADDRESS THE
UNDERLYING PROBLEMS OF POOR URBAN COMMUNITIES**

Unfortunately, managed care as it exists in New York City, with its profit-making motivation and competitive conditions, not only increases the financial pressures on safety net health providers in poor neighborhoods, but also has created some new access barriers to health care for the poor.

A managed-care system can do nothing to enhance access to appropriate care unless enrollees know how to use the system. Last year, the Community Service Society conducted interviews with Medicaid beneficiaries and found that most of them are confused about how to get care within their plan and are poorly educated about the basic concepts of managed care.

The interviews produced a number of horror stories of Medicaid recipients trying to get access to health care:

- A major concern in managed care has been deceitful enrollment practices. An East Harlem woman had an ongoing relationship with her health center. She was approached at the center by a plan representative whose plan was not accepted at that center and was told that she had to join a plan. Lacking appropriate information, she joined the plan that solicited her, thinking she could continue coming to the health center for care. The next time she went to the health center, she was refused care because the center was not affiliated with her plan.
- Another common problem is that plans are over capacity, and enrollees are unable to obtain appointments in a timely manner. Instead of reaching out to new members to ensure their connection to a primary care provider, plans are unable to make appointments even for those who reach out on their own. A Puerto Rican mother from the Bronx had been a member of a plan for more than two years; her son had not received a checkup in that time. When she called to make an appointment, she was told to call back and try again in a few months.
- Many of those we spoke with told of being denied care at an emergency department because they were enrolled in a health plan. People who are uninsured or are enrolled in the “wrong” plan cannot access medical aid even in extreme conditions. A 32-year-old African-American woman who

had been raped was denied treatment at two different hospital emergency departments because her Medicaid card indicated that she was enrolled in a plan not accepted at those hospitals.

Our study found that Medicaid recipients cannot always get access to medical care when they need it, they are ping-ponged around the system without explanation, and they believe that they receive second-rate care because they are poor. They conveyed a strong sense of frustration, anger, and powerlessness about the system of managed care.

Nonetheless, the managed-care train is rolling. As a result of the new Balanced Budget Act, it is easier for states to convert their Medicaid programs to a mandatory managed-care system. This will have an enormous impact in urban areas with large numbers of the poor. In New York City, 1.9 million Medicaid recipients, mostly people of color, will soon be enrolled in a managed-care plan, whether the capacity exists or not; whether they know how to use managed care or not.

I do not say that managed care cannot work, but it must be properly implemented. Like too many things affecting the poor, Medicaid managed care has been driven in response to budgetary considerations rather than the best interests of patient care. Everyone agrees that the fee-for-service system we currently have has done a miserable job taking care of poor people. Managed care must be done right.

REQUIREMENTS FOR AN EFFECTIVE URBAN HEALTH CARE SYSTEM

If the health care system is to succeed and be effective, it must be community based, oriented toward primary care, sufficiently funded, and accessible to all. What does this mean?

- Providers need to become better aligned with the communities they serve. Representation on the decision-making bodies from the constituencies that actually use the system is essential. This requires more than the tokenism of consumer representatives on advisory boards. It would be in the interests of the health care industry—hospitals and health centers, as well as managed-care plans—to include client members voluntarily on their boards. Their input would be invaluable to operations and would not cost the industry anything.
- Medical schools should rethink the types of students they want to recruit, so they end up with the kinds of providers the health care system needs. We can do a much better job of identifying students who will be committed to providing primary care in poor neighborhoods, then nurturing those

students through their education and supporting them as they begin new practices in underserved neighborhoods.

- Public funding must be found to ensure universal coverage. The costs of health care will never be tamed in America until all people can get adequate health care. The health care cost of the uninsured is a huge burden that is increasingly falling on public hospitals and clinics, which are likely to collapse under the weight of that burden. In the long term, universal health care coverage would both cut costs and promote better health.

We are presented today with an opportunity to start anew in providing decent health care for our neediest citizens. We must avoid the mistakes and neglect of the past. The remedies are known:

- Coverage must be universal and adequately funded.
- Safety net institutions require a structure of financing that is sustainable over time.
- The client base—Medicaid recipients, the uninsured, people of color, those who actually use the system—should be represented on the policy-making boards of the health care industry.
- Health care should be community based, with physicians and facilities seen as integral parts of the communities they serve.
- Medical schools that receive public funds should be offering incentives to encourage their graduates to practice in minority neighborhoods.
- Medical training programs should reflect the primary care needs of the community. Medical schools that receive public funds should be obligated by the government to produce more primary care physicians and more minority physicians. Medical schools have not been creative in working with other parts of the educational system in devising programs for promising students that would help prepare them for medical school. Each medical school ought to implement its own agenda to deal with this problem.
- Community-based providers are desperately needed in poor urban neighborhoods. Partly in response to the recommendations from our study of the conditions of health care services in poor neighborhoods, the Primary Care Development Corporation (PCDC) was formed in 1993 as a public/private partnership to expand primary care services in New York's medically underserved communities by making financial resources and technical assistance available to nonprofit health providers. While this is commendable, it is slow, and we need to think harder about how to expand primary care capacity.
- The problems of access to health care by those living in poor urban neighbor-

hoods—lack of home phones, cost of transportation, language and literacy—must be acknowledged and addressed.

- Government should monitor the operations and practices of the HMO industry, and there should be an ombudsman function at the state level.
- We need a plan for the long-term stability of the public health system in New York City. It makes no sense to privatize the facilities of the Health and Hospitals Corporation or for the city to cut its subsidy to the corporation when the number of uninsured is rising.

If these conditions are met, and the people and organizations involved in providing health care act with goodwill and foresight, then perhaps we can avoid turning the health care industry into an institutional slum in which the poor are warehoused and their health needs are ignored. The failure to provide adequate health care for the poor, in the long run, will adversely affect our entire communities, making urban living more onerous for all. For the sake of our cities and the most vulnerable of our citizens, we must not let this happen.