URBAN HEALTH POLICY

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Urban health policy is almost a contradiction in terms. The context or contexts of urban health rarely seem to be conducive to reaching some agreement on what is wanted from urban health policy, which makes the job of designing it an exercise in frustration. Urban health policy seems often to be made by committees that do not understand each other.

There is nothing new about this situation. The Old Testament describes it in the story about the Tower of Babel. More recently, in 1966, when President Johnson signed the Model Cities Program into law, the Hydra nature of urban health policy raised its heads again. The Model Cities Program was a significant effort in its time, but it also illustrated how difficult it is to formulate and carry out an urban health policy.

MODEL CITIES: EXERCISE IN URBAN POLICY MAKING

In the mid-1960s, US cities were in crisis. Rioting was occurring and there was much concern about the future of the cities. The Office of Economic Opportunity had been created to promote community action, but that was in roughly a thousand American communities; it was not really an urban program, and there was growing sentiment on the part of President Johnson and his advisors that there ought to be a program for the cities. There ought to be a genuine federal urban program.

Johnson's advisors pointed out that there was already much federal money in the cities; nobody was talking about this as a domestic Marshall Plan, as they used to say. The problem was that the money did not get spent properly, and it was not properly targeted or concentrated. As a result, the money was not able to break the "cycle of poverty."

A program was proposed that would concentrate federal money on the most severe problems of the worst-off neighborhoods of a subset of hard-pressed cities.

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The attempt would be made, in a serious fashion, to match the resources to the needs. Initially, it was to be called the Demonstration Cities Program, but President Johnson grumbled that there were already too many demonstrations around the White House and elsewhere, so they changed the title to Model Cities.

What happened? The first plan called for concentration of planning effort and a lot of money on a very few cities, perhaps five or six. Cities with manifest urban problems were considered. Then, however, the policy planners wondered, who was going to say no to all the Democratic mayors that would not have their cities funded? It was considered politic to have several more cities, perhaps 50. Then, the policy makers thought about the realities of getting the program through Congress. Fifty cities were considered too few to be approved by 100 senators and 435 representatives. They ended up with what they felt was the minimum set necessary to get the bill passed, which turned out to be 150 cities. That defused the resources rather considerably. I was always amused to note that the city I grew up in, Binghamton, New York, with 65,000 people at that time, was a Model City.

With the cities picked, the next part of the plan was to concentrate the money on specific areas within the city. Rather than spread the resources over the entire city (in each of the 150 cities), the planners intended to pick the model neighborhood that had the worst problems and concentrate on the problems of that area. How would that be accomplished? Generally, the mayor of the city identified the model areas, and elections were held within those areas for citizen boards. Resident participants helped to set priorities through some collaborative effort on the part of city hall and elected representatives from the Model Neighborhood.

As one resident said, somewhat plaintively, "everything is a priority." In short order, dozens of priorities were found, and it was very difficult to say no to someone. If the duly elected representatives of the neighborhood said, "This is the priority of the people that I'm speaking for," an administrator could not say, "Sorry, it's not a high-end priority." The result was long laundry lists, sometimes extending to 50 or 60 or more projects, and one could understand why. Education, housing, law enforcement, jobs, and neighborhood health centers were all high-priority needs. So, the money became defused further among these various policy areas, across the "model" cities, and the promise of concentrated targeted resources grew more distant.

There was a supposed saving grace to the process. The money that was appropriated through the Department of Housing and Urban Development (HUD) for the Model Cities Program was not supposed to be the lion's share of

the funds. It was merely supposed to be catalytic, to put together staffs and other activities, as part of the process of priority setting at the local level. The intent was that cities could apply subsequently for federal categorical grants and harmonize these grants around the needs of the model area. The grants would not come mostly from HUD, but from what was then the Department of Health, Education, and Welfare (HEW), the Department of Labor, and such. The Model Cities appropriation was supposed to be just a drop in the bucket.

However, when the Model Cities staffers in these 150 communities inquired to see what would be entailed in getting the programs for their neighborhoods, they discovered, to their dismay, that most of these programs had very different statutory bases and requirements and different budgetary procedures, and oftentimes they worked through the states. HUD typically worked directly with the cities, but HEW typically worked through states and localities. HUD and HEW had very different administrative styles and preconditions. Their regional offices and the use of them in awarding program funds differed considerably; they had different clienteles. The Model Cities staffers saw immediately that it would be a slow, hard, long, frustrating strategy to accumulate those federal grants; allocation patterns did not fit the presumptions and presuppositions of targeting such monies on one section of a so-called Model City.

So, the HUD money, small as it was and diffused as it was among priorities and cities, ended up being the lion's share of what was spent on Model Cities.

The idea was a good one, but, as foretold in Genesis, it was diffused all over the land in the same way as the languages were scattered when the Tower of Babel was destroyed. The money was spread across 150 cities and was further diffused over dozens of priorities within those cities. It was spread among people who really did speak different languages, in a certain sense, and sometimes literally; there is enormous heterogeneity within the inner cities of our hard-pressed larger cities. It also encountered a different language problem, a particularly frustrating one, when Model Cities proponents discovered that the federal agencies did not speak each other's language either when it came to concentrating these resources on an area or jurisdiction.

In 1974, the Model Cities Program came to an end. Then there was a great deal of talk at the federal level about revenue sharing and block grants and things that would diffuse money, in many respects taking money away from HUD's categorical programs for cities and putting it out in the counties and the suburbs that were growing rapidly. There was very little talk thereafter, however, about federal urban policy nor has there been much since, even under Carter and Clinton, our two Democratic presidents since Lyndon Johnson.

LESSON TO BE LEARNED

The Model Cities experience shows that the policy context for urban health can be summarized as one of keeping the focus. The diffusion of focus and resources must be avoided, and would-be policy makers must learn to speak a common language about what is really meant by urban policy and what should be done about it. One can begin, accurately enough, with the observation that urban health problems are serious and represent a real national priority. Then, however, one must try to determine what a "priority" means. What problems will be a program's focus? What approaches should one take? How will objectives be met? How will resources be allocated concretely among cities? Diffusion and confusion reign. Policy grows uncertain and grinds to a halt.

Some examples of the difficulty may be illustrative. It seems a self-evident proposition that urban places have health problems that are so serious as to constitute a major national priority. For practical purposes, the question is, however, what is "urban"? What is meant by health policy for urban areas? New York City, Los Angeles, and Houston obviously have very severe problems that could be addressed through federal urban policy, but then what if one adds cities the size of, say, Trenton, New Jersey, Charlotte, North Carolina, and Sarasota, Florida? What about small cities, such as Elmira, New York, and Yakima, Washington? All are cities; all are urban places in a formal definition. Does urban, when one discusses health policy, mean just the big cities? Does it mean big cities with hard-pressed center cities with many poor people living in them? How big does a city have to be to be eligible for federal urban health policy or urban health policy at the state level?

If one defines urban in a too-exclusive way and the cities have to be too big and too few, as with Model Cities, no coalition is possible; you do not have the votes. If the coalition embraces much smaller places, enough of them to provide the political power to proceed, then can something effective be done about the problems, given the diffusion of resources? The focus becomes blurred over the political geography issue of the size of the city. Can one indeed define a core of salient needs that is common to these cities of all sizes and descriptions?

Another example illustrates the role of perspective. To the proposition that the cities have especially intense needs and are worse off than nonurban places for all kinds of reasons, a skeptic might reply that the cities also have especially rich institutional resources. Cities are where one finds most academic health centers, public hospitals, and community health centers as a consequence of federal and other policies. Critics will also say that the suburbs are where most of the population growth is occurring, and that center cities are losing populations.

An equitable public policy, they would say, is one that has the resources following the people and their presumed needs.

Moreover, as was true in the Model Cities Program, whenever people talk about targeting resources on one neighborhood and one city, the legislators will immediately say, "What about the rural areas?" Some states, such as Virginia, have much rural poverty and few resources. Critics will contend that the cities have many resources already, but do not use them sensibly.

Once again, the focus blurs rather quickly about where cities fit into the larger scheme of government jurisdictions, and the focus blurs further over the issue of whether the discussion should center on new resources allocated to the cities or a better use of the resources that are already present. In either case, how does one relate resources to genuine needs?

For a third example, urban health policy makers may contend that cities are home to concentrations of America's most disadvantaged, the most needy citizens with respect to health care. Therefore, urban policy exerts a special moral claim, a claim of social justice on our efforts and our resources. Such an argument plays very well in the Upper East Side and the Upper West Side of Manhattan, but not so well in Peoria these days. Peoria may have fewer disadvantaged citizens and fewer urban dwellers who are not citizens at all. The United States has had a highly distasteful debate lately about whether undocumented aliens have a right to health care. Some of our city dwellers are immigrants and are legal enough, but there is a good deal of resentment against them and their claims on resources. That resentment is increased in the case of some who are needy because they have engaged in what is perceived to be immoral or unsavory behavior, such as using and dealing in drugs, getting pregnant out of wedlock, and acquiring human immunodeficiency virus (HIV) through unsafe sex.

Voices will be raised to proclaim that such notions constitute blaming the victim. That is probably true. On the other hand, in the present political climate and this post-Reagan era, plenty of taxpayers see themselves as the victim, being asked to pick up the bill for irresponsible behavior on the part of a population that is concentrated in the center cities. That makes for a rather hard sell, and the focus blurs again, from what seems to be an incontestable moral proposition to a debate, the old American debate, about who are the deserving poor, who are the undeserving poor, and what should be done about them?

As another example, consider the incontestable proposition that health care is a top priority for reform for the urban disadvantaged. Perhaps it is. As the Model Cities example about priorities suggests, urban populations need many different benefits and services: jobs, income support, educational improvements,

housing, law enforcement, and better nutrition. Health care is just one item on that list. It is an important item, but it is not necessarily the most important item. To complicate the issue even further, health care is not necessarily the item on the list that is most conducive to the health of these populations. Some communities are trying to improve health and safety by reducing violence, drugs, teen pregnancy, and the like. Many of them are saying that health care is very important, but maybe we should put more emphasis on education so that children will be able to read well by the third grade, and will not face nine more demoralizing years before "graduation," and so may be more inclined to get something out of school and plan for the future rather than dropping out and getting involved in illicit activities. Maybe education is the root, rather than health services, conventionally defined. Maybe jobs are key.

Such considerations are important to contemplate. Again, however, the focus blurs on the issue of the place and the priority of health care in this mix of social needs and services and what is most conducive to improved health. The focus is not necessarily on more spending on health care and health programs.

Cities have a special claim to the aid of policy makers because they are hit especially hard by the transformations that are sweeping over our system at present, and they have a special claim to assistance. After all, purchasers are driving harder bargains, so there is less slack in insurance premiums with which to cross-subsidize uninsured populations. There is less support for essential community providers and public hospitals, leaving urban populations vulnerable. The public-sector safety net is in tatters. Hospital downsizing hurts the urban poor because it costs them jobs, and also it damages their access because they have less resort to easy transportation when nearby facilities are closed. This proposition is true and is not confined to big cities. Small cities and rural areas may be even more dependent on the fate of their community hospital as a source of employment and economic activity. In some places, when the hospital—the major employer—closes, the community is finished. The grocery store owner and the furniture repairperson and the gas station attendant will not be far behind in closing up their businesses and leaving town.

If those who are less well off are being hurt economically by the supposed efficiencies that we are introducing, it is not clear that the urban poor, particularly the center-city poor, are a special case deserving special attention. They may be, but the issue is not decided. In any case, the focus again blurs over the implications of these larger trends for vulnerable populations.

As a final example, consider the proposition that urban health problems really are not in any deep sense urban at all. The financing system is really at fault,

and if universal coverage could be achieved, we would have solved our urban health problems. Medicaid covers only about half of the poor in this country; more citizens have no insurance at all than are enrolled in the Medicaid program. Some would say that securing coverage for all is the key to an effective urban health policy. I am inclined to agree. Is it, however, the answer? Notwithstanding the egalitarianism of the British National Health Service, for example, significant inequities or disparities persist across social class lines, across regional lines, and across disease category lines. This has been a continuing, and in some ways growing, source of concern in Europe; the disparities that persist even under national health insurance have led to such movements as the Healthy Cities movement in Europe, which seems to be rather little appreciated or analyzed in the United States.*

So again, the focus blurs. Is the core issue a financial one that universal coverage would cure, or, even if the United States achieved such coverage, do we still have to revisit the issue of what the city's distinctive needs are?

URBAN HEALTH POLICY: THE BOTTOM LINE

Cities have real liabilities, and this has always been true. They are home to waves of poor people, including foreigners; they have been subject to these upstate-downstate or in-state-out-of-state splits that can be quite bitter in political terms; they are the sites of internal tensions and divisions over race, class, ethnicity, and the like; they are more heterogeneous than smaller types of jurisdictions, which makes for much suspicion, not only among the urban dwellers themselves, but between them and the more homogeneous, suburban community dwellers, say, who resent the idea of all those suspect people hanging out down there, taking one's tax money.

All kinds of conflicts are fought over political turf, and there is a pervasive antiurban bias in many of our states and regions. They sense that cities are losing population relative to suburbs, that their day has come and gone, and that suburbs are the center of action where one should concentrate resources. There is also a sense of job loss and loss of economic activities in the cities, causing them to be a drain on the resources of the region. Such conflicts and perceptions lead to the blurring of focus when one discusses the benevolent impulses of urban health policy, the scattering of resources over the policy landscape, and an inability to come up with a common language, or a common discourse, to

*Those interested in learning about the movement can consult the Healthy Cities site on the World Wide Web: <http://www.healthycities.org>.

discuss urban health care problems. It seems to me that the loss of focus lingers, year in, year out, and decade in, decade out.

Perhaps concentrating on cities *per se* will not be successful in the realities of the policy context and the political context. Perhaps the discussion about urban policy must be linked to something bigger and broader, larger coalitions, serving larger populations.

I think that a successful urban health policy depends on answering these kinds of questions and others like them. The discussion must remain focused so that some policy discourse and common terms will supervene.