TOWARD IMPLEMENTATION OF AN AGENDA

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The New York Academy of Medicine is to be congratulated for organizing the symposium on realizing an urban health agenda. It is especially fitting as part of the Academy's 150th anniversary celebration, for a concern with public health, of which urban health is a major part, has long characterized the Academy.

THE REALIZATION OF A PUBLIC HEALTH AGENDA

There is a disconnection in our society, and those of us who are involved in public health have not found a way to deal with it in an effective way. A recent Harris poll queried the American public about public health. The interest in and knowledge about public health was embarrassingly little, and I can attest to that. In comparison with deans of such schools as those of business, medicine, or law or of a college, people understand what the schools do, at least to a certain extent. However, as the dean of the School of Public Health, most people have no idea what such a school does and, after I am introduced, the first question I am asked is, "What is a school of public health?"

The same Harris poll revealed, however, that, when people were asked about some of the values and activities of the field of public health, there was very strong support for all of them. Somehow, we in public health have not been able to bring together the positive atmosphere and attitudes about what we do with the title "public health." Some have said that we need a new name.

How can an urban health agenda be accomplished and implemented? One way, if it were possible, might be to clone a person such as Mayor Schmoke of Baltimore, Maryland, and send his clones to the major inner-city areas in the United States and let them do their thing. The leadership of such persons is essential, as was pointed out by many at the symposium.

Committed and visionary leadership can make a difference. I lived for a

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number of years in Thailand, and while there working with the Ministry of Health, I spent much time all over the country, particularly in the rural areas. It struck me how underserved the rural populations were at that time, even though there were some physicians and auxiliary midwives and nurses; yet, the services by and large were very poorly utilized. Every once in a while, however, we would come to a town or a village or a community where there was an exceptional leader in the health care field, or even in the political sector, and everything then seemed to work. It was clear that what was working, in the end, was the individual who was leading the program rather than any structural element.

Leadership really is of key importance. Unfortunately, there are many American cities, but few leaders that speak with the kind of commitment to the society and the community as was voiced by Mayor Schmoke at the symposium and is published in this issue.

Able leaders are needed because there is so much that demands their leadership. The health status of the poor, particularly the urban poor, and the determinants of ill health were quite eloquently stated by several of the speakers at this symposium. Remarkable efforts are under way in different parts of the country, but similar efforts are needed in other communities.

The problems related to inner-city urban health are compounded severely by the problems of poverty that plague these areas. Wallace and Fullilove and their colleagues have used a geographic perspective to document the signs of spreading urban decay and its impact on health and other components of social well-being in the urban setting.¹⁻⁵ It is not easy, therefore, to plan the implementation of solutions to the kinds of problems noted at the symposium without considering ways to overcome the inequities that exist in our society or without considering the social fabric of poverty and the failure to date of approaches to ending the spread of poverty and its consequences.

Even in the face of an unusually healthy economy, we have the insanity of a system in which health care is a privilege, not a right. This is a truly incredible situation in the world's largest and economically most successful and powerful country. It is shocking that close to 20% of our population, or some 43 million people, are uninsured. This number, unfortunately, continues to grow. As Dr. Davis noted at the symposium, over 50% of these people are the working poor. In a system that relies predominantly on employer-based insurance or on the federal government for Medicare and Medicaid, these are people who do not receive insurance from their employer, find the rates for private insurance simply too high, are too young for Medicare, and are not poor enough to qualify for Medicaid.

Unfortunately, in part because of the high cost of health care and because health insurance is a fringe benefit, many companies are hiring more and more part-time employees to avoid the necessity of providing health insurance. Many small businesses that hire entry-level workers do not provide health insurance or other fringe benefits.

In 1993, the nation lost a golden opportunity to enact a plan for universal health coverage. In my opinion, this was the single greatest failure of the Clinton years. It was on the public's agenda; it was number one or two in most of the polls at the time as an issue. Whether it might have been possible to pass an employer mandate, rather than the complex system that was proposed, or a single-payer system is not clear. For many middle-income people, as well as for most physicians, either of these approaches might well be considered preferable in comparison with what has evolved since the plan failed.

I was intrigued by several of the Baltimore initiatives described by Mayor Schموke at the symposium because I think that there are lessons there for all of us. As stressed by many of the other presenters, the community must be a partner and a participant and must be truly involved. Making that more than simple rhetoric is not easy and requires much work and compromise on both sides, then a real effort for better mutual understanding, then planning together. The Baltimore experience, with the community-based Healthy Start program, is one that can be emulated almost everywhere, albeit adapted appropriately to local conditions.

At Columbia School of Public Health, the Center for Population and Family Health works closely with our predominantly Hispanic community, with the Presbyterian Hospital's Ambulatory Care Network, and with the Departments of Obstetrics and Gynecology, Pediatrics, and Psychiatry in developing a superb preventive and service program focused on teens. The program includes evening clinics for both young women and young men; school-based clinics in four junior high schools, one in our senior high school, and soon another in a special high school for pregnant teens; a popular certificate educational program for parents; and a series of special programs related to jobs and education for the teens. A key component of all these activities has been the use of multidisciplinary teams. We think that these programs are of critical importance if we hope to do more about teen pregnancy, sexually transmitted diseases, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), teen drug use, teen smoking, and other problems.

The Columbia School of Public Health and the Harlem Hospital Center, with funding support from the Centers for Disease Control and Prevention, have created the Harlem Prevention Center, in which we work with church, mosque,

and other community groups, to attempt to develop a better understanding of the excess mortality that exists in central Harlem and to develop prevention-oriented programs to have an impact on this problem.

THE OVERARCHING ISSUE

The problems of poverty, of inequitable distribution of resources, of rising numbers of the uninsured, of inadequate educational opportunity, and of community and household violence are all major societal problems, perhaps beyond the reach of the health care field. Nevertheless, health care practitioners must be involved. So, too, must other sectors of our society. Effective partnerships between the public and private sectors are essential to the development of solutions to these problems. We must involve community groups, schools, universities, health departments, and others. We need to think about the Healthy 2000 and Healthy 2010 goals and to work on these together. Funding, dedication, and commitment on the part of the many players are required if we hope to have any measurable impact on some of these problems.

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