KEYNOTE ADDRESS: CREATIVE PARTNERSHIPS FOR HEALTHIER CITIES

THE HONORABLE KURT L. SCHMOKE

The symposium to celebrate the sesquicentennial of the New York Academy of Medicine dealt with one of the most difficult and complex issues facing society today: how do we improve the health of our nation's urban dwellers, particularly those living in the poorest parts of our inner-city neighborhoods? As mayor of a major American city, I am called upon to try to answer that question almost daily. There are no simple prescriptions.

As is true of so many of our nation's large, older cities, Baltimore, Maryland's poor citizens face a daunting array of health problems. Among them are a high level of infant mortality and a high incidence of low-birth-weight babies, both of which relate directly to other ills, such as our city's high incidence of teenaged mothers. Only a few years ago, Baltimore had one of the highest teen birth rates in the nation. Because of our aging housing stock, we also have the significant problem of lead poisoning, with its pernicious effects on our children's ability to succeed in school.

Baltimore's inner-city residents suffer disproportionately from chronic illnesses. Rates of tuberculosis, asthma, and diabetes are high, and, because of the thousands of drug addicts in our city, we must contend with the terrible scourge of acquired immunodeficiency syndrome (AIDS), as well as the accompanying rise in crime and violence that continues to tear apart certain of our communities.

Many of those who live in Baltimore's inner-city neighborhoods are also among the poorest residents in Maryland. Too many of these people live on the edge of existence: they must deal with inadequate housing, high unemployment,

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low wages, and few opportunities. Too often, these urban families are victims of violence in their own homes, as well as on the street.

These two pictures of inner-city Baltimore—poor health and economic distress—are related. It appears that, wherever one finds a high concentration of poverty, one also finds a concentration of health problems.

Dr. Martin Luther King once said, "Of all the forms of inequality, injustice in health is the most shocking and the most inhumane." Today, that injustice in health continues to be most prevalent in America's most distressed inner-city neighborhoods. The situation is dismal, but it is not yet desperate.

The sesquicentennial symposium sought to go beyond descriptions of the multiple health problems faced by city residents and their devastating long-term impact on urban communities. Its broader purpose was to highlight programs and strategies that are working effectively in our urban communities and to propose new approaches to further improve the quality of life in America's poorest neighborhoods. Baltimore's urban health agenda offers examples of such approaches.

BALTIMORE: BACKGROUND FACTS AND PERSPECTIVE

Baltimore is a city of about 700,000 people. About 60% of its population is African-American; it has a small Latino population. No county health department has an impact on the city. Baltimore, I think, is one of three American cities that has no corporate relationship with the surrounding county; this city of 700,000 people operates as though it were a county.

There are more children in the New York City public school system than there are people living in Baltimore. We are the 14th largest city in the United States. New York, Chicago, and Los Angeles are much larger than we are; many other notable cities—the New Havens, the Bridgeports—are much smaller.

BALTIMORE PROGRAMS

The city of Baltimore has undertaken several health initiatives that have resulted in significant progress. We are making some progress in a few areas, and we expect to do even better. These initiatives are not only instructive in their own right, but also reflect the range of public health approaches, partnerships, and funding sources that can create and sustain a healthier urban community.

As mayor of the city, I am proud that Baltimore is making some significant inroads in some of these difficult health areas. I believe that this progress is due in large part to innovative partnerships that we have forged over the years with both traditional and unlikely allies. The health of many of our inner-city residents is, in fact, improving. Nevertheless, serious barriers continue to stand in the way of full recovery.

HEALTHY START

Healthy Start is a program familiar to many. It is Baltimore's community-based program to reduce the incidence of infant mortality and improve the health of Baltimore's very youngest citizens and their mothers. The program is a unique prevention effort because it seeks not only to reduce the occurrence of low-birth-weight babies, but also to increase economic opportunities for the families of young children.

The program is federally funded. It is now in its fifth year in Baltimore and is targeted at two of our most distressed neighborhoods. The Healthy Start outreach efforts are led by neighborhood health advocates, women who go door to door recruiting pregnant women into the program. Once a woman is recruited, her health advocate helps her to get the prenatal health care and other services she needs—including drug abuse counseling and treatment when necessary—to increase her chances for a healthy birth. After the baby is born, the health advocate continues to guide the mother and help her obtain any additional assistance she may need for her baby to grow and thrive.

Healthy Start is credited with more than helping us to lower the infant mortality rate by an impressive 35% in our poorest communities over the past six years. It is also a job program: it employs approximately 120 community residents as neighborhood health advocates. The intertwined goals of promoting better health and increasing economic opportunity apply to the program's nationally recognized men's services unit as well. This program helps partners of women who are enrolled in Healthy Start to become more-responsible fathers, and, since maintaining employment is an integral part of being a responsible father, the program has also helped some men to obtain construction and other jobs in the community.

Unfortunately, the federal funding of this model program is in jeopardy. Although we have regained some of the recent cuts, we are now searching for other nongovernmental partners, including Johns Hopkins University (particularly its School of Public Health) and the University of Maryland Medical System, to help us continue the outreach and home visiting programs that are so vital for maintaining the health and well-being of high-risk families.

PROGRAMS TO DEAL WITH TEENAGED PREGNANCY

Teen pregnancy is another health challenge facing Baltimore. The city's health department and public schools have formed a strong partnership to combat this complex problem.

Baltimore has 183 schools. We have 17 school-based clinics in selected middle and high schools; these clinics not only provide primary health care for adoles-

cents, but also offer family planning counseling and contraceptive methods for those who are sexually active.

The city has established a teen clinic in one of Baltimore's most popular shopping malls as a way of reaching adolescents in less-threatening and more-familiar territory. In addition, we have strengthened our prevention efforts by introducing an abstinence curriculum and establishing abstinence support groups in our public schools in the hope of persuading more teens not to take that first step of becoming sexually active or, just as important, encouraging those who have become secondarily abstinent to remain so.

The result of this multiprong approach has been a 16% decrease in the teen birth rate between 1990 and 1995. This is a major accomplishment, given that Baltimore had one of the nation's highest teen birth rates in the 1980s.

EFFORTS TO COMBAT LEAD POISONING

Lead poisoning is a prevalent problem in older cities such as Baltimore. That problem, too, is complex: it highlights the interplay of social conditions, health, crime, and poverty that is present in many of the issues discussed at the symposium.

Lead-paint poisoning does the greatest damage to our youngest children, leading to significant behavioral and learning disabilities and putting those children at far greater risk of dropping out of school and into trouble. Not surprisingly, the problem of lead poisoning is greatest in America's poor inner-city neighborhoods, where we have a concentration of old and run-down housing.

Although the city of Baltimore has developed an effective strategy of prevention and early intervention based on home visits and educational campaigns to improve the environmental conditions in people's homes, we have also hit some difficult roadblocks, particularly in the area of lead abatement. Most of the houses that are found to be in violation are old and dilapidated rental units; their owners are either unable or unwilling to make the repairs to prevent lead poisoning. Landlords often abandon property that they cannot or will not maintain. This, in turn, increases the number of run-down, boarded-up houses in our inner-city neighborhoods, limiting further the quality of affordable housing. Such conditions hurt the quality of life in the urban core, encourage crime, and exacerbate the economic decline in inner-city neighborhoods.

The problem of lead abatement illustrates once again how closely urban health problems are intertwined with other social and economic challenges, and emphasizes that we must work more collaboratively with a wider range of partners if we are to make long-term progress in restoring the health of our nation's cities.

IMMUNIZATIONS

Adequate immunizations are essential in our efforts to protect children from a range of lethal and disabling diseases. Yet, for years, Baltimore's immunization efforts, even for school-aged children, had been floundering; immunization compliance rates were in the 60% range for our school population. We have made dramatic progress in this area, however, and have received a boost in this effort from a very unlikely source.

A few years ago, Baltimore became the first city in the United States to sponsor a Lessons Without Borders conference. The Lessons Without Borders program was founded by the United States Agency for International Development (USAID) to determine if some of the strategies developed by USAID to improve life in developing nations could be used successfully in inner-city communities in the United States. For Baltimore, the answer was clearly yes. As part of our participation in the Lessons program, a team of public health officials and community residents visited an immunization project run by women in Kenya. They learned strategies that they later applied in Baltimore, including a far more aggressive educational outreach program. As a result, we have been able to increase our school immunization compliance rates from 62% to 99% in just two years. In Baltimore, we had to face the painful fact that some of our health problems, particularly in the inner core city, were very similar to problems in poor third-world countries. Some of these same underdeveloped countries had discovered effective community-based health strategies, however, and we learned from them.

IMPROVEMENTS

The successes described thus far—Healthy Start, teen pregnancy programs, child immunization—reflect an upward swing in the general health of Baltimore's inner-city residents. That good news has several facets:

- In 1996, 94% of Baltimore city's expectant women reported having received prenatal care in their first or second trimester of pregnancy, the highest level we have ever recorded.
- The infant mortality rate has improved dramatically over the last six years.
- Birth rates among Baltimore city teenagers, aged 15 to 19, have declined.
- Baltimore is recording the lowest number of tuberculosis cases in its history.
- Since 1991, there has been a 51% decrease in the number of gonorrhea cases in the city of Baltimore.

We are making a difference. Sometimes our progress is due to a revitalized and innovative health department. Sometimes it reflects advances in medicines,

such as the new triple cocktail that is being used to decrease the mortality rate of AIDS patients. Sometimes progress happens because we look to emerging nations overseas for clues to improve the health of our highest-risk populations. More often, however, Baltimore's progress is due to its partnerships with schools, churches, other faith-based organizations, medical institutions and community based clinics, and various levels of federal and state government; these partnerships are helping to improve the lives of inner-city residents.

PROBLEMS CURRENTLY BEING ADDRESSED

Although Baltimore's health picture is improving, the cruel fact is that we cannot continue to make progress in individual health areas until we face the broader social and health issues that plague our cities. I subsume these issues into one metaphor: the three-headed monster of AIDS, addiction, and crime. I believe that the combination of these three public health factors has had the single greatest impact on the quality of life in our cities. Baltimore has several efforts under way in an attempt to slay this monster.

A number of us have been saying for some time now that the nation's current drug policy does not work and cannot be made to work. We have called for a new strategy, one based on public health, to address the drug problem that is having such a devastating impact on our nation's inner-city neighborhoods. In Baltimore, for example, 85% of felonies are drug related. At least 65% of our new AIDS cases are in those who are injection drug users, while another 15% involve their sexual partners and children. These trends hold even though both crime rates and AIDS mortality rates are dropping.

Cutting crime and preventing the spread of AIDS remain the two most compelling reasons I know for changing our current drug policy. I believe that policy should be based on a public health approach that I have termed *medicalization*.

The medicalization strategy, which treats drug addiction as a disease and not a crime, must accomplish three things:

1. It must increase substance abuse prevention efforts.
2. It must offer an ongoing continuum of substance abuse treatment on demand.
3. It must provide harm-reduction measures, including maintenance for hard-core drug users who refuse or fail treatment repeatedly.

This approach, among other benefits, would help take most of the profit out of street-level drug trafficking. It is the profits that drive the crime.

In Baltimore, we have begun to tackle this complex problem in a number of ways, primarily through our needle-exchange program. Baltimore's needle-

exchange program is a harm-reduction effort designed to limit the harm addicts are doing to themselves and to others as the result of their addictions.

A few statistics illustrate the extraordinary reach of this problem that we are trying to solve. Baltimore's health and police departments estimate that, among Baltimore's 700,000 people, there are 59,000 heroin and cocaine addicts. Our police commissioner estimates that it takes about \$3.5 million a day in criminal activity to support their habits. The enormous social cost in lost jobs, broken families, innocent victims, and deepening poverty are more difficult to measure.

The needle-exchange program, however, is beginning to turn those statistics and our quality of life around. Started in 1994, Baltimore's needle-exchange program has grown to become the largest local-government-run needle-exchange program in the United States; it serves more than 7,000 addicts, and we are proud of the progress that we are making:

- We are reducing the transmission of human immunodeficiency virus (HIV) among injection drug users. Johns Hopkins University (School of Public Health) researchers, who recently evaluated the program,* found that enrolled addicts lower their risk of contracting AIDS by almost 40%.
- We are getting more people off the streets and into drug treatment centers. Again, according to the Johns Hopkins study, the success rate of our needle-exchange clients in drug treatment is remarkable.
- We are helping addicts to get help. There is a 20% reduction in the frequency of drug use among program participants, as well as large reductions in needle sharing and other dangerous behaviors that put addicts at risk for AIDS.
- We are saving money. Direct expenses for serving these 7,000 addicts in the program annually are \$300,000. The average cost to the state of Maryland to care for one adult AIDS patient from diagnosis with AIDS to death is about \$102,000. If we have protected even three addicts from being infected (our estimate is many times that number), we have already saved the taxpayers money.
- We are having an impact on the reduction of crime. That is not one of our primary objectives in the program, but it is a welcome collateral effect. In one recent study, addicts who enrolled in drug treatment slots that have been reserved for our needle-exchange clients reduced their illegal income from \$800 a month to about \$10 a month. That means they steal less. In addition, another study found that crime in the vicinity of the needle-ex-

*Findings were unpublished at press time.

change sites dropped about 20%, a rate comparable to our overall drop in crime in the city.

WORK TO BE DONE

We are proud about the successes of Baltimore's program, but we realize that we have not won the battle to turn around our nation's drug policy. To do that, we need to engage both the commanders and the foot soldiers.

Congress, for example, must lift its ban that prohibits federal spending on needle-exchange programs. Even though such efforts have been endorsed by the American Medical Association, the Centers for Disease Control and Prevention, the National Institutes of Health, the National Academy of Sciences, and the U.S. Conference of Mayors, the ban remains.

The foot soldiers, however, are already joining the ranks. Ordinary citizens in Baltimore have supported the city's needle-exchange program and are now clamoring for more treatment centers in hard-pressed neighborhoods.

We are getting an increase in positive publicity. A few days before the sesqui-centennial symposium, for example, we received unlikely support from Miss America, Miss Kate Shendle, who came to Baltimore. Her visit was noteworthy because, after she won the Miss America pageant and was asked about her issue for the year, she said that it was to raise consciousness about AIDS and to combat the problem. When she was asked a question about needle exchange, she said that she thought it was a contradiction in terms and would not support it. I invited her to visit Baltimore, and our health commissioner, Dr. Peter Beilenson, followed up with some details. Miss Shendle came to Baltimore, visited one of our toughest neighborhoods, and brought national attention to our needle-exchange efforts. At the conclusion of her visit, she made a very strong, positive statement about the need for needle exchange as one of many strategies in combating the spread of AIDS.

More recently, Baltimore received further confirmation of the soundness of our multiprong health strategy. Once again, the confirmation came from an unexpected source: a philanthropist, George Soros, announced that he is giving Baltimore \$25 million to support drug treatment and related social and economic development programs in our city.

We believe that our approach is working. I will continue to advocate the medicalization approach to our national drug policy, including a major thrust to expand resources for drug treatment, which resulted in the doubling of funds committed by the city of Baltimore in 1997, because I believe that this is the most humane and most effective strategy in the war against drugs. Until we solve this inner-related and complex dilemma, which collectively we call the drug problem,

I am convinced that we cannot make significant headway in solving the myriad other urban health issues that concern us today.

LESSONS FROM THE BALTIMORE EXPERIENCE

Some lessons from our experience in Baltimore may contribute to other discussions about improving urban health:

1. In this age of ever-diminishing public funds, we must expand our search for partners in health. In Baltimore, some of our most effective health collaborations are with local churches, community-based clinics, and local public schools. We are also seeing more private foundations, as well as the business community, becoming our partners in improving the health and well-being of our inner-city residents.
2. We must place a far greater emphasis on community outreach. Urban health problems are difficult to solve, in part because many of those in greatest need of help are difficult, if not impossible, to find. We must go to them. We should do so by any means available, such as placing family planning clinics in shopping malls, organizing door-to-door health visits, or expanding the number of needle-exchange vans on city street corners.
3. We must recognize the vital link among social conditions, health, crime, and poverty. Health problems are compounded by the physical and economic deterioration in our cities; we must build comprehensive strategies that address a broader spectrum of social needs. Just as a good physician treats a patient's symptoms only after reaching a diagnosis, we must improve health care services in urban neighborhoods and at the same time address the underlying causes of poor health, such as violence, homelessness, crime, and inadequate housing.
4. We must acknowledge some of the environmental justice issues that affect the health and welfare of our urban citizens. We cannot allow our poor communities to continue to be dumping grounds for toxic waste and other environmental health hazards. We must also shift the emphasis from treating the immediate health problems in a crisis-oriented, fragmented way and focus more on changing long-term behaviors and habits. Accordingly, we must place a higher priority on prevention and education campaigns to encourage people to live healthier lives—to stop smoking, start exercising, stop drinking, and establish healthier diets. We must provide far more support services to drug addicts, to help them to free themselves from their destructive and deadly behavior and thus lessen the harm they do to themselves and their communities.

5. Finally, we must be prepared to take risks and look for inspiration and support from unconventional sources. Who would have thought that village women in Kenya could help us improve our immunization strategies in inner-city Baltimore? Who would have predicted that the highly controversial idea of changing our drug policy that has been debated for the last few decades would today be partially implemented on the streets of Baltimore and be making a positive difference in the quality of life?

These are some of the issues that I believe are of very great significance to our urban communities. The most critical issue of our time is improving the health and well-being of our inner-city communities. It is an extraordinarily complex and difficult mission. I am grateful that the New York Academy of Medicine has the courage and the vision to place that challenge at the top of its agenda as we enter the next century.