URBAN HEALTH CARE: WHAT WORKS AND WHY

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The United States lags behind the developed world in such health statistics as infant mortality rate and life expectancy from birth. Probably the major reason we do so badly is the health of people in our inner cities.

Traditionally, philanthropies like the Robert Wood Johnson Foundation and others in the health care sector have addressed the problem by saying, "Let's improve access to care, let's give more health care services. In particular, let's expand access to primary care." We know from the work of John Billings and others that hospitalizations for conditions that are amenable to primary care, such as asthma or heart failure, can be reduced if more primary care is available. Improving access has been a traditional philanthropic strategy.

We also know that secondary and tertiary care are very popular with the public. The public wants these services to be available when needed, even though they are not needed often. This has been another incentive to supply services.

Expansion of health insurance is one way to expand access to services. Forty-one million people do not have health insurance; that number is probably rising. Accordingly, the Robert Wood Johnson Foundation and New York State (among others) have been trying to expand health insurance coverage.

It is interesting that the group that probably needs insurance the most is comprised of adults who are not yet old enough to be in the Medicare program, but have retired or have lost their jobs. Such people are at highest risk for health care. It is much more economical, however, to expand coverage for people at the lower end of the age spectrum, and it makes a certain amount of sense. Politically, it is a very "sellable" thing to do, as was made clear by the expansion of coverage for children that occurred in 1997.

One cannot argue with expansion of health care coverage for children, espe-

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cially because a disproportionate number of people in the inner cities are children, but many have come to the conclusion that if we are to improve the health of our people and be competitive with the United Kingdom or Germany, or even Japan or Sweden, in terms of improving health statistics, we will not achieve the objective merely by providing more health care. Almost 15% of the US gross domestic product is allocated for health care now. Clearly, the nation could make progress if those dollars were distributed more efficiently and effectively.

If the United States is to improve the health of people living in its cities, it must address some of the underlying issues that result in teenaged pregnancy, sexually transmitted diseases, substance abuse, acquired immunodeficiency syndrome (AIDS), and violence. Unfortunately, those solutions do not lend themselves well to the health care delivery model.

FOUNDATION PROGRAMS

I have been at our foundation for seven years. The Robert Wood Johnson Foundation has given away more than $2 billion to try to improve the health and health care of the people of this country, and yet I can offer at best only a partial answer to the question, "What works?" Because the question has not, to date, been answered fully, the foundation is changing its philosophy; it is trying new approaches. In the early years, the foundation's grant-making activities were driven by the sense that national health insurance was imminent, requiring that supply be expanded in order to meet the pent-up demand that would be unleashed as national health insurance came into being. The foundation helped to fund primary care, nurse practitioners and community-based clinics, and rural health clinics. That was a good thing to do, and, in general, the health status of urban populations improved slightly. Still, the United States was not faring much better in comparison with other countries as a result of these activities.

More recently, even as it has maintained its traditional interests, the Robert Wood Johnson Foundation also has been focusing increasingly on the more difficult issues that lie at the boundary of social policy, public health, and clinical medicine. Two national programs are illustrative because they attempt to involve local communities in addressing problems that are important for them: Fighting Back and the Urban Health Initiative.

Fighting Back

The Fighting Back program attempts to encourage communities to address the problems of alcohol and drugs. It started in 14 communities; 8 retain programs now. Originally, the Robert Wood Johnson Foundation conceived of the program as a 5-year, up-and-out effort, much in the tradition of foundation programs

in the past. Now, however, we are committed to 10 years or longer. The goal is to foster coalitions among clergy, schools, police, medical leaders, civic leaders, and business leaders. Communities have approached this program in different ways.

Some communities, such as Santa Barbara, California, have major alcohol and drug problems. Santa Barbara has assembled a variety of very creative campaigns that focus on the media. Kansas City, Missouri, brought together a very imaginative combination of clergy, police, people who work in local philanthropies, and the mayor's office. This coalition constructed a mock cemetery in which all the people who have died from substance abuse are memorialized; a New Year's Eve vigil is held each year.

The Robert Wood Johnson Foundation worked diligently with these communities and invested a considerable amount of money in the programs. It then conducted a preliminary evaluation of each city, which included two comparison sites for each. Factors such as substance abuse rates and rates of incarceration were examined; to the astonishment of the people on the front lines, there was no difference between the eight Fighting Back cities and the control communities, which were following national trends.

It is worth recalling the Multiple Risk Factor Intervention Trial, which was conducted approximately 15 years ago. That trial enrolled men who were at risk for heart disease and subjected them to a strenuous regimen of exercise and a cholesterol-lowering diet. To the astonishment of those investigators, the subjects fared no better than the control group, but the control group was much better at the end of the trial than it had been at the beginning. Most probably, the national trend toward reduction of cigarette smoking, a better diet, and more exercise inadvertently made the control group behave more like the experimental group than had been anticipated, thus blunting the effect of the interventions.

After at least five years of monitoring, the foundation's Fighting Back program still shows no difference between experimental and control sites. The foundation's board wondered whether the experiment was tried, failed, and should be terminated, but one of the things that philanthropy can do is to take risks and persist.

The board decided to persist. It was guided by two factors; the first is the hope that results will appear over time. In the early 1970s, economist Thomas Schelling of Harvard University observed that social problems can resemble an infectious disease epidemic; that is, they do not increase or decrease in a linear fashion.[1] Rather, the situation may remain at a relatively stable point until a threshold is crossed, after which extensive changes can occur. In "The Tipping

Point," an article in the *New Yorker*,[2] Malcolm Gladwell used a quotation from his father to illustrate that concept: "Tomato ketchup in a bottle. None will come, and then a lot'll." His article noted several examples of the phenomenon. One study found that when a community had a certain minimal level of people who worked at professional jobs—the level could be as low as approximately 5%—the community stayed stable. If out-migration—that is, professionals leaving the neighborhood—dropped below 5%, however, a tremendous increase in the measures of dysfunction occurred in the community, such as teenage pregnancies, school dropouts, drug use, and murders.[2]

The concept of a tipping point is daunting to philanthropies. It may mean that one reason we have not achieved the desired result is that we have not yet put enough resources in. Success may be just around the corner. But, lack of success may also have nothing to do with a tipping point; the intervention may simply be ineffective. It is difficult to discern where a tipping point might be.

Is the Fighting Back program about to hit the magic moment in the ketchup bottle, or is the problem so daunting that the approach is wrong or the amount of resources is insufficient? We simply do not know.

The second factor that persuaded the foundation to persist in its support of the Fighting Back program was the hope that, even if the intervention failed to produce positive results, details of the experience would be helpful to others working in the field. At the very least, we hope that we will learn from what happened and be able to share that with others.

Urban Health Initiative

The other illustrative Robert Wood Johnson Foundation program, the Urban Health Initiative, is in its early stages. In this effort, the foundation will work with five large cities over a long period of time, probably about a decade. We say to these communities, "We want you to form a robust coalition that has the capacity to make things better for children. We want you to pick an important problem that affects the youth of your community, and we want you to work on that. We will provide technical assistance and core support."

We tell these communities:

> You've got to prove to us that the issue that you're working on is salient, but otherwise, you're free to choose it. It might be teenage pregnancy; it might be drug abuse; it might be violence. We will work with you to try to make a difference, and we will not do the hit-and-run things that we and other philanthropies have sometimes done in the past. We will remain for a long time, and we are going to try to reach a tipping point with you.

The problems that are being addressed in the Urban Health Initiative have no easy solutions. In my opinion, the most important ingredient for success in

these cities is leadership. When the Robert Wood Johnson Foundation and other foundations have programs that work, we have tended to fool ourselves by saying, "Well, it's this formula; it's making the grantees do such and such." When we consider our programs more carefully, however, what really has worked has been sustained leadership—the ability to mobilize people in the community, to make difficult decisions, to persist over the long run, to deal at the intersection of wealth and poverty, to persevere in the racial cauldron that so bedevils efforts to try to improve things. If I could do one thing, it would be to clone the gene for leadership and then to insert it into people who are faced with running these various programs.

Because the tasks are daunting and solutions are elusive, it is tempting, sometimes, to declare a problem intractable and to look the other way. For example, McCord and Freeman's paper in the *New England Journal of Medicine* showed that a young male in Harlem has less chance of living to age 40 than his counterpart in Bangladesh;[3] findings of that sort may tempt us to say that we are going to write off that community and others like it.

SUCCESSES

Despite the foregoing cases, in many instances, the situation is better in our cities than was the case seven or eight years ago. For example, two remarkable outcomes were reported in 1997, for homicides and for children's health coverage.

Homicides

The decrease in homicides has been dramatic. In Boston, for example, there was an 80% decrease in the number of youth homicides between 1990 and 1995. This has been happening not just in Boston, but elsewhere. A lot of people take credit for it, including mayors who run for re-election and people who advocate extra efforts in community policing.

One reason for the decline in homicides is the decline in the use of crack cocaine and its associated criminal traffic, and a sense on the part of the community that it has had enough, as evidenced by a resurgence of interest by the churches. It is difficult to discern the reason(s) for this outcome, but it is very important to celebrate it. It is evidence that progress can be made.

I think that the national debate about the proper role of government and the responsibility of communities may be beneficial. If it is not as clear that the political calculus of the day will allocate these problems to government to solve, and as they fall back on other groups, perhaps we are beginning to find the right balance for progress. It is important to pause for a moment and reflect on where this country was in 1988 or 1990 and where it is now.

Children's Health Coverage

A second event that occurred in 1997, the expansion of health insurance coverage for children, surprised many. In the wake of the failed Clinton health plan, and with the current tsunami of antigovernment feeling, there was a tendency on the part of the health policy experts in Washington and elsewhere to say of the 41 million people who did not have health insurance, "Well, that's too bad, but that's an enduring feature of our country. We're going to have to live with that."

In the past few years, the Foundation conducted some explorations and did some writing to determine if we could at least start with children's coverage. Because most poor, sick children are already on Medicaid, we reasoned that it would not take a great deal of money per capita to expand coverage for children. We calculated that about half of the approximately 10 million children that do not have health insurance coverage are eligible for Medicaid, but are not covered for a variety of reasons, some of them bureaucratic. We wondered, therefore, whether something could be done to secure coverage for those eligible children. We talked to some of the pundits in Washington, but were told that there would be no expansion in the era of budget deficit and tax reduction.

In the summer of 1997, $24 billion in funding was included in the Balanced Budget Act to expand coverage for children over the next five years. If the states accept this challenge (it is not clear that they will), 5 million or more of the 10 million children now uncovered will have health insurance.

I noted above that increased health care is probably not the most efficient way to improve the health status of our country. Nevertheless, if children with asthma can get to a primary care doctor or nurse, and if they can get their medications paid for, they will not go to a hospital or emergency room for care. That will lower costs, and the children will be healthier.

WHAT WORKS?

The following list of what works should be considered an opinion, not a prescription. Nevertheless, it represents a distillation of the Robert Wood Johnson Foundation's experience regarding urban programs.

1. The problem(s) must be identified.
2. The multiplicity of causes and actions that will be needed to remedy most of the problems must be recognized.
3. Tenacity is essential. The program should be allowed to persist over time, even when the data may look bad, because it may get that final shake of the ketchup bottle, and a flood of desired outcomes will ensue.
4. Inspired leadership must be sought, and it must be supported through all

the difficulties associated with the effort to lead in this country in such a politically confusing time.

5. People must be sought who are willing to work in areas that are not as fashionable as they used to be, and that perhaps do not pay well; they will have the wonderful ethos of helping other people.

REFERENCES

1. Schelling TC. *Neighborhood Tipping*. Cambridge, Mass: Harvard Institute of Economic Research; 1969.
2. Gladwell M. The tipping point. *The New Yorker*. June 3, 1996; pp. 32–38.
3. McCord C, Freeman HP. Excess mortality in Harlem. *New Engl J Med*. 1990;322:173–177.