S. HRG. 103-618

SOLVING THE URBAN HEALTH CARE CRISIS: THE ROLE FOR PREVENTION

HEARING

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

ON

EXAMINING URBAN HEALTH CARE PROBLEMS AND THE ROLE OF HEALTH DELIVERY IN PREVENTIVE MEDICINE IN THIS COMMONWEALTH AND IN THIS CITY, THROWING LIGHT ON THE PROBLEMS OF THE NATION AND ON LEGISLATION WHICH HOPEFULLY WILL BE ENACTED THIS YEAR

MARCH 15, 1993 (PHILADELPHIA, PA)

Printed for the use of the Committee on Labor and Human Resources

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SOLVING THE URBAN HEALTH CARE CRISIS: THE ROLE FOR PREVENTION

MONDAY, MARCH 15, 1993

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Philadelphia, PA.

The committee met, pursuant to notice, at 9:38 a.m., in the Feinstone Lounge, Sullivan Hall, Temple University, Philadelphia, PA, Senator Harris Wofford, presiding.

Present: Senator Wofford.

OPENING STATEMENT OF SENATOR WOFFORD

Senator WOFFORD. Welcome, everyone, to this field hearing of the Senate Labor and Human Resources Committee on urban health care problems and the role of the delivery of preventive health services in this Commonwealth and in this city, and in our Nation and on legislation which we hope to enact this year.

I salute you for not being frozen out or snowed out and for being here. I want to first of all salute the Temple team that was on duty and welcomed us warmly. They were here before we got here at 8 o'clock, and I would like the President of Temple University, one of the great leaders in our Commonwealth, to say a few words in opening this hearing for us, Peter Leacoris.

Darrel Jodrey, the head of our health care team, was sitting at my left and is now sitting at my right.

Peter.

Mr. LEACORIS. Thank you very much, Senator, and good morning to everyone. We thank you very much, Senator, for choosing Temple for the site of this hearing.

It was you in your campaign 2 years ago that set the tone for the crisis in health care, whether it should become a focal point for change in America, and now the issue is not whether it should be the focal point but how, in what parameters the changes should take place.

It would have been quite easy for the United States Senator from Pennsylvania to postpone today's hearing, given the conditions outside, but the issue is of such great importance and Senator Wofford's commitment for change is so apparent that the hearing is taking place, and I congratulate you, Senator and Mrs. Wofford, for going through with this commitment to hold this hearing and to hear of the need for change and parameters for change in the health care system.

So Senator, welcome to another university. This is not exactly Bryn Mawr. We think Bryn Mawr is a fine institution, and you will hear what Temple University in the emergency area faces symptomatic of other major urban hospitals and rural hospitals face with the tremendous burgeoning costs of health care.

So again, welcome to everyone and thank you again for coming, Senator.

Senator WOFFORD. Thank you, Peter Leacoris, and I also want to thank your new executive vice president, James White. Jim White goes from one frontier to another, from military leadership to the City of Philadelphia to the front lines with Temple, and Provost England is here who is developing Temple's role in the national service movement and the new proposal by the President. Dr. Leon Malamud, who is the Vice President for Health Sciences and heads the extraordinary School of Medicine and hospital and health services of Temple University, a salute to all of you.

By the way, Peter, we had no problem finding out how to wind our way in and out of snowdrifts nearby here because my spouse, Claire Wofford, is a Temple trustee and comes here often. I was the one that got us around the snowdrifts but she knew where to go, as is usual the case in our lives together.

I was going to spare you my opening statement because we had so many people ready to be heard, and we have a wonderful panel right now ready to be heard, but we have lost several of our witnesses to the snow. Representative David Richardson is snowbound and will probably not get here. Marian Tasco, a very dynamic leader of our city council, is snowbound in Buffalo.

We will be back, because this is not the end, it is just another step in a long process that I will be in the thick of and that I have been in since I got to Washington. The legislative situation is speeding up with the President's proposal due in May, and I will be back and back and back as we keep you informed of what is happening there and you keep me informed of what I need to know and to do in shaping the health care agenda.

But let me say a few words. It may be freezing cold outside, but the iron truly is hot on the issue of health care reform and now is the moment, this year, to hammer out a plan in the very months ahead that finally turns the right to affordable health care into a reality for every American.

Now that is probably the biggest difference between the spring of 1991 and the soon-to-be, we believe, somehow, somewhere soon, spring of 1993. Two years ago, there was no political consensus on the need to reform our health care system. People of Pennsylvania helped change that in November 1991 with a wake-up call to Washington that it was time for action on health care reform. And in November 1992, the American people then delivered the national mandate that we would need to get action.

So we are no longer having a debate over whether to reform our health care system. Instead, now we are having a national discussion of how to do it. That is a discussion that we helped start last month in Harrisburg when Hillary Clinton and Tipper Gore joined us for our large-scale Pennsylvania health care conference. Now they have taken our model and they are doing the same kind of forum all over the country

So today we have come to North Philadelphia to focus that conversation on a key part of the Nation's health care crisis and the solutions to it, the health of people who live in our inner cities. Over the past decade, changes in health financing policies have steadily eroded the incentive for delivering care to uninsured patients who are in greatest need.

As people here at Temple know only too well, taking care of the sickest patients, those who arrive on the hospital doorstep through the emergency room, has become a very expensive proposition. Make no mistake about it, we are all paying the price for that care through our private insurance premiums, lost wages, and higher taxes.

The other day I was in a taxi with a driver who said, I took the risk, I didn't take out any health insurance, I got stabbed, I was out of commission 6 months. My hospital bill was $33,000. I was able to pay over $1,000 but I couldn't pay anything more. They stopped writing me letters after a year and put me in some special category. Well, you know the category. The category is the costs were shifted to the other people's plans, your plans, government programs. That is just one aspect of the financing crisis.

More than half the increase in the Federal budget deficit predicted between now and the year 2000 will come from increased health care costs unless we do something about it. We are especially talking about costs of Medicaid and Medicare. The problem is even worse for the states and local governments, which have never had the dangerous luxury of running deficits year after year.

Worst of all is the fact that so many of the problems that present themselves at big-city hospital emergency rooms could have been avoided. As a Nation, we now spend over $900 billion a year, one-seventh of our economy, one out of every seven dollars we spend in this country, for health care, and we are about to pass the $1 trillion mark. Less than 3 percent of that money is going to be spent on preventive services unless we do something about it, whereas a huge percentage of those costs are the result of diseases that are preventable.

More importantly, then, there is the human cost, which we are going to hear a little about in just a few minutes. The infant mortality rate in Philadelphia has been among the highest in the country, especially for nonwhite babies. Preventive illness is rampant among the inner-city population, including hypertension, lead poisoning, AIDS, other infectious diseases, as well as the brutal violence that has reached truly epidemic proportions among our young people.

A number of infectious childhood diseases are almost completely preventable through routine immunization, but too many children, especially in the inner city, still don't receive adequate immunization. In 1990, we saw a completely avoidable increase in the number of children with measles, which sometimes can cause death or severe disability.

The human costs of these preventable diseases come with staggering economic costs. The lifetime cost of treating a child with congenital rubella can be as high as $400,000, yet it could have been prevented if the mother had been immunized for $30. The control of high blood pressure is another example where one of the

most effective means for reducing deaths for heart disease and stroke is at hand if we take action. For every dollar invested today in preventing lead poisoning, we will save at least $2 in the future.

Even more dramatic is the impact of low-cost prenatal care. A year ago, I brought Bill Clinton to the neonatal intensive care unit at Pennsylvania Hospital down in center city. We saw tiny low-birthweight babies whose care ran into hundreds of thousands of dollars, and I have seen babies where the doctor said, this is a million-dollar baby. It has cost us $1 million to save this baby. But if their mothers had received a few hundred dollars of prenatal care, those babies could have been born healthy. It is the same story in every hospital in this country.

Last year, I introduced, together with Senator Tom Daschle of South Dakota, comprehensive reform legislation that would create a Federal structure for delivering a basic package of health care benefits to everyone in this country throughout their lives regardless of where they live or work. It would lead to states and communities the flexibility to shape their own distinctive approaches for providing this coverage, but the core benefits would include primary and preventive care for everyone.

I have been working to ensure that the plan that emerges from Hillary Clinton's task force and eventually from Congress will retain this strong emphasis on preventive and primary care, and I am confident that it will. No doubt, it is going to be a major challenge to extend that care to every family in every community.

The network of programs funded under the Public Health Service will play an even bigger role in the future in providing prevention services and especially in inner-city areas. They include community health centers, the Ryan White Program for areas hit hardest by AIDS, the preventive health services block grant, and other efforts by the Centers for Disease Control and Prevention.

This morning, we will hear from public officials and private citizens who have been struggling with our existing health care system. Our witnesses will tell us about both persistent public health problems as well as emerging challenges we need to be aware of as we craft comprehensive health reform legislation. But more importantly, they will help our committee in Congress see how Philadelphia's experience with preventive health programs can serve as models of success to be expanded under a reformed health care system.

I will proceed with the first panel, and I think Senator Williams is not yet here. Senator Williams is coming in.

Senator Williams, could you join me up here at my left? If you will join me here for the questioning, we put the first panel on first and you will be then the beginning of the next round.

Let me introduce briefly our citizen witnesses. We have now four citizen witnesses who will share their personal experiences with getting access to preventive health care services. Aleah Lockman is here, Kim Bey is here, Bernard Johnson is here, and our fourth is Frederic Kauffman. I thank them for braving the snow and for the sense of urgency they have about this problem.

I know it is not easy sometimes to talk about personal matters. We often learn, however, the most in this world from personal stories. That is why I especially appreciate our three citizen witnesses

being here, including Dr. Kauffman, who is Director of the Emergency Department here at Temple University. He will share with the committee his experience in the emergency room, confronting what is often the cost of a lack of preventive primary care services.

I welcome you all, and Darrel, do you have an order? Should Aleah Lockman maybe start first, and then Kim Bey?

STATEMENTS OF ALEAH LOCKMAN, PHILADELPHIA, PA; KIM BEY, PHILADELPHIA, PA; BERNARD JOHNSON, PHILADELPHIA, PA; AND FREDERIC KAUFFMAN, M.D., DIRECTOR, EMERGENCY DEPARTMENT, TEMPLE UNIVERSITY

Ms. LOCKMAN. Good morning.

My name is Aleah Lockman. I am a 23-year-old college graduate, mother of one 6-month-old baby boy and a part-time seasonal employee at H&R Block.

I am here this morning representing the Covenent House Health Care Services. I became a part of the Covenent House Health Care Services because at the time last year I became pregnant and I was a student at the University of Maryland, Eastern Shore. At the time, I did have health coverage but they did not take it in Maryland. I had to therefore come back to Pennsylvania to receive health care service.

By me being a senior in college, about the time my child was born, 2 months before my child was born I was put off my mother's health care plan and I couldn't afford to continue with the services. The services that I received from the plan my mother had didn't even cover half of the prenatal care that I needed. I ended up paying for such things as ultra sounds and other tests that were need in prenatal care.

I went to the Covenent House. They took the necessary procedures for me to get on medical assistance so therefore I can have full health coverage for the birth of my child and for prenatal care. I chose to receive prenatal care through the Covenent House and they helped me with the necessary procedures to get medical assistance for my son once my insurance ran out.

I received prenatal care and I found out that at the Covenent House they were really concerned about me and my well-being, even though I had to travel back and forth from Maryland to Pennsylvania to get care. The times I was here in Pennsylvania, in Philadelphia interviewing, the Covenent House worked with me and made sure that once a month I made it home to get prenatal care, and if anything came up, any test or anything, the nurse contacted me personally and it was very confidential and they sent the necessary prescriptions for prenatal vitamins or if I had any infections, for me to get them filled in Maryland.

When I first came to the facility, I felt very comfortable and I was very impressed with the service. Employees there set up the necessary paperwork for when I was to go into the hospital for labor and delivery during my first visit. They also placed me in all the programs that I qualified for, such as WIC, which enabled me to get the proper nutrients, milk, cheese or whatever, like so I can eat right for my pregnancy.

I was also assigned a social worker, which is right there on their facilities. If I qualify for any other government-aided programs, I was welcome to apply.

What really impressed me about the Covenent House, like I said before, was the confidentiality that they have with their clients. Even if I had to return to Maryland, if I had any problems, any questions, they welcomed me to call them anytime with any questions or any problems that I had. They were like a support group the whole time I was away. Even when I came home, it was even better when I came home.

After I graduated in May, I moved back to Philadelphia and the Covenent House offered me more programs. We had prenatal classes for 4 weeks, they were two hours once a week, and they also had home visitation programs where an expecting parent can receive one-on-one information for those unanswered questions that couldn't be answered during the time we had the prenatal classes.

The prenatal classes acted as a support group for me and other expecting parents. Everyone in my class was experiencing being pregnant for the first time, so we could really relate to each other as far as the feelings or the nervousness and everything. The classes covered all medications you could receive while in labor and delivery and the effect that they would have on you and your child. They covered the pros and cons of breast feeding versus bottle feeding, breathing techniques, and birth control, and that is only a few of the things they covered.

The home visitation program also stressed the importance of immunizations and they follow up on you and your child until your child is 1 year old.

What I found of great importance at the Covenent House is that the doctors are on call 24 hours for emergency. If you have any emergencies, you can call their emergency number and they will contact you right away and give you the necessary things, procedures to do to care for your child rather than go to the emergency room. It is a hotline that you can call and they will follow up on you and everything.

I had to use the hotline several times, being as though for my family this is the first baby in the family since I was born, which was 23 years ago, so a lot of things have changed and it is just a lot of things that my mom forgot or we just don't know, and it has been a real help. They handle things as minor as diarrhea to as serious as breathing problems, because one time my son started wheezing and everything and I didn't know what was going on, so we went to the hospital and they followed up on everything on me, and it was a real help because I got all nervous and crazy-acting, but they calmed me down and they were real supportive about it.

Well, basically, the Covenent House, like I said, has provided convenience for me as well as equal or greater-quality health care as other facilities would have, and it is all under one roof, so that is what I really like about it. And because of the services I have received, I am now better aware of the importance of health care in the lives of my son and myself.

Thank you.

Senator WOFFORD. Thank you very much.

Did you say that you are working now?

Ms. LOCKMAN. I am just a seasonal employee for H&R Block down the street.

Senator WOFFORD. As a part-time worker, do you have health insurance benefits now?

Ms. LOCKMAN. No, I don't. No, I don't. I am still on medical assistance.

Senator WOFFORD. Unless you want to ask a question right now, we will ask Kim Bey, and then talk to the panel afterwards.

Kim Bey, would you tell your story? Move the microphone around so the technology helps.

Mr. WILLIAMS. Ms. Lockman, how old are you?

Ms. LOCKMAN. I am 23 years old.

Ms. BEY. Good morning. My name is Kim Bey and I appreciate being given the opportunity to speak to the Committee on Labor and Human Resources and tell you what the role for prevention has done for me and my family.

I am 29 years old and a single parent of three children, ages 7, 6, and 3. I am also recovering from a drug addiction for 3 years. I am currently enrolled in a community college to obtain a certificate in drug and alcohol counseling. Prior to my new way of life, I was in an addiction for 4 years and the end result was homelessness and in desperate need for treatment and health care.

I went into treatment when I was 7 months pregnant with my third child. Up until then, I had no prenatal care and I was not eating the proper diet to have a healthy baby. Gardenzia New Image, which is a treatment center for homeless women and children, gave me the support and attention I needed to get healthier. At the clinic, I was treated for an infection which helped me to have a healthy baby.

After 5 months in the facility, my second child came to live with me in treatment. He was three at the time. He was very withdrawn and full of anger and aggressiveness. My chemical dependency had affected him and my family emotionally and they needed help from the child care component at Gardenzia. They helped me learn how to communicate with him and gave me suggestions in parenting skills so I could build a healthy relationship with him so it could prevent him from being a part of the violence and crime that takes place in our city.

After I completed treatment, my oldest child also needed counseling to build her counseling in me and help her with her self esteem. Her grades were very poor and as a result of her counseling, they went from C's and D's to A's and B's All of these services were provided to me through medical assistance and I am very proud to be a parent today.

The services contribute a great deal in the role for prevention. It is very important for them to continue so other people like me can have the same opportunity.

Senator WOFFORD. Thank you very much.

Mr. WILLIAMS. How old are you, Ms. Bey?

Ms. BEY. Twenty-nine.

Senator WOFFORD. I may have missed it, did you say what you are doing now? You are at the community——

Ms. BEY. Right.

Senator WOFFORD. You are at the community college?

Ms. BEY. Right.
Senator WOFFORD. In paralegal?
Ms. BEY. No, D&A counseling.
Senator WOFFORD. D&A, good.
Bernard Johnson, would you, Mr. Johnson, tell us your story?
Mr. JOHNSON. First, I would like to just start out by saying God is great. Any time a sister can sit next to us and explain to a roomful of strangers what her problems are and how she has recovered from them, I just need to say God is great.

I would like to thank Ron Heigler for inviting me here this morning. Ron is the Director of Greater Philadelphia Health Action. I have known him for about 10 years now, and my family are patients at his facility on Woodland Avenue.

I am also the director of Healthy Family, Healthy Life, a family-centered community-based health organization in southwest Philadelphia attempting to do in the neighborhoods for people who aren't strong like this sister here, attempting to introduce them to programs around health prevention.

I am also the father of two daughters. One is 14 years old and the other is seven, and both of those children were born at risk just because of the way my wife carries children. Everyone isn't on drugs when their children are born at risk, and I just need to say that.

So our problem was somewhat different than a lot of people's problems. We were fully insured at the first two births. I worked for an employer, we had Blue Cross/Blue Shield, and my wife had major bowel surgery in her sixth month of pregnancy with our first child, but we had insurance and we were able to survive that. The second child was born 7 months and we were again insured and we survived that. Both of those kids are now doing well.

About a month ago—I will just tell this most recent situation—about a month ago, our oldest daughter began complaining about severe stomach pains, and we are underinsured right now. We are not fully insured. We piece together different types of insurance. My oldest daughter, who is covered under the Caring Program from Blue Cross, began experiencing these pains and so we took her to the doctor.

Because of the Caring Program, we were able to have her fully examined, something that we would not have been able to do, at least as far as I am concerned, we wouldn't have been able to do it without that program. So we found out that my daughter had a cyst on one of her ovaries and it needed to be surgically removed, and it presented a problem for us because the Caring Program only covers outpatient services.

When we went to see what the possibilities were of upgrading our coverage with Blue Cross, we got some bad information in the sense that the person who was talking to us felt as though the card would cover inpatient surgery. It made us feel good when we got that information, so we went on to the surgeon, only to find out that the card doesn't cover that type of surgery.

So I called Ms. Marshall, who happens to be in the room right now, and I talked to her about it. She is from Blue Cross. I talked to her about it and she worked with us and in a day or so she called us back. The people in the surgeon's office didn't understand

how they should get us in the hospital, which was really confusing to us. We needed to have this operation but we didn't know how to get into the hospital, and so Ms. Marshall told us about several programs that the hospital could offer us. We talked to the surgeon, the surgeon talked to her social worker, and that process began to move. So we got involved in the spend-down program.

If it hadn't been for that good information—we got some bad information, then we got some good information, but if hadn't been for that, we don't know what we would have been doing right now because it didn't seem that the doctor's office, the social worker, the people in the hospital were sending us back and forth. We were just flying back and forth, back and forth.

Well, in the end, last week the cyst disappeared and my daughter didn't need the surgery after all, but Blue Cross, the Caring Program, covered some $1,500 worth of outpatient evaluations and testing that would have been very difficult for us to pay out of our pocket.

So that is the most recent situation that we have been involved in. There are a lot of folks who are out here who are uninsured or underinsured. I just want to say that maybe it is my pride that keeps us from going to the welfare department to see if we are eligible for public assistance, maybe it is the way people are treated when they go into the welfare department that keeps us from wanting to go into that situation, but if public health benefits could be offered to people from community-based organizations, if they could be offered from health clinics, from places outside of the welfare department, I think we would find more people willing to go into those places and apply for benefits.

So if it is true that 30 percent of the people who are uninsured are eligible for public assistance benefits but for some reason don't apply for them, maybe we need to be looking at the reasons why they don't apply and the barriers that are set up to keep people from applying for benefits that they are truly entitled to.

That is basically my story this morning.

Senator WOFFORD. One question I have for all three of you is to what extent do you feel that you have one-stop service? How important was that, that there was one place and one program that was able to deal with a great many of your health problems?

Ms. LOCKMAN. Well, at the Covenent House, like I said before, everything was right there that you needed and they helped you. If you needed any type of other assistance, the social workers were right there on the premises. If you qualify for the WIC program, that was right there on the premises. Everything you needed to have a healthy child was provided for you right there. They explained everything to you. It was just a matter of you agreeing to go along with the program. Everything was right there, all the services that you needed were right there in that facility.

Senator WOFFORD. Ms. Bey.

Ms. BEY. Yes, all the services were at Gardenzia also. Before I went there, I had a difficult time trying to get help because I was homeless and pregnant, but their facility supported me with everything that I needed.

Senator WOFFORD. Bernard, do you have any thoughts?

Mr. JOHNSON. We didn't experience the one-stop shopping privilege. We had to make many thoughts. All I am saying is that——

Senator WOFFORD. Do you want to describe that again, how many hoops you had to go through?

Mr. JOHNSON. Well, we started at Blue Cross, we talked on the phone, they told us to go into the office. We went into the office, we got what we thought was good information. It turned out that the information wasn't correct. That is really bad, when you pass out bad information to people who are all up in the air anyway about what is happening to them.

I called Dr. Ross' office and talked to folks in his office. I was just trying to get information. Information is important. Then we went to the surgeon and the surgeon didn't know what was going on. That was another stop.

So we made five or six pit stops before we were able to convince people about the program of spend down, and I am not exactly sure what that program is all about right now because, like I said, the cyst dissolved itself and we didn't have to carry through with the surgery.

But if one-stop—I live in an underserviced neighborhood. Senator Williams represents that neighborhood to some degree. He is from that neighborhood. It is underserviced. There are no social services in the community. It is King Sesson, where we have the second-highest rate of infant mortality in the city, and there are no services there. It is difficult to get information.

So my family wasn't privileged like these ladies were, and if there was a program of its kind in my community, we would have taken advantage of it. And we think that we are on top of things and every day that goes past, we find out more and more that we know less and less.

But one-stop shopping is something that our organization is pushing for, is something that most people in the health industry say they want, but it is taking forever to happen at the rate it needs to happen, Senator. It is not there for everyone. It is certainly not there for people who work every day and struggle every day working these five-member shops, six-member shops, working grocery stores. Folks need information.

Senator WOFFORD. Senator Williams.

Mr. WILLIAMS. You referred to Greater Philadelphia Health Action Organization. Could you describe what kind of organization that is? I am aware that it is a well-run grass roots kind of health approach that has been eminently successful, and it is African-American run and I think you ought to lay that out for us.

Mr. JOHNSON. Sure. I started out in the city's health clinic, my family and I, when we lost our health insurance, and that was several years ago. We weren't happy with just the appearance of the place and the wait, the long wait, and the rudeness of the physicians, to be honest with you, before Dr. Ross came.

We went to Greater Philadelphia Health Action, which runs one of its centers at 55th and Woodland, and we went there basically because I had known Ron Heigler and A.J. Henley who was there before Ron Heigler, so we figured we would go there to try to move ourselves away from the city facility. If the place is dirty, you just

don't want your family treated there, and it was terrible, District Health Center Number 3. At that point in time, it was terrible.

So we went up to Ron's place, and I talk like that because that is how the people up there treat you. They treat you decent, the place is clean. I mean, the place is clean, so in your eyes, that is the first thing you are looking at is how clean the place is. You get one physician. You see that physician each and every time.

I even went to the doctor. I mean, you talk about men's health, I was feeling real bad a couple of years ago. I was like 40 pounds overweight, so I finally drug myself up to the doctor after my wife encouraged me to do so and he told me, you keep on going like this and you are going to be out of here. I lost some weight. He told me what to eat, what not to eat, so I changed my diet. It is a struggle, but I changed my diet and I appreciate the service there. It is like going to your own doctor.

Folks understand what I am talking about. When I was a kid, we had one doctor, one doctor. And we moved about three times when I was a kid and we had that one doctor who delivered all my sister's kids. I was comfortable. That is how I was raised. I was comfortable with that type of care. That is the type of care that GPHA offers you at 55th and Woodland.

Mr. WILLIAMS. In addition to that 55th and Woodland site for general health care, is there another facility nearby where they basically address the needs of children? I think it is at 55th and——

Mr. JOHNSON. They have a day care center, you mean?

Mr. WILLIAMS. A day care center.

Mr. JOHNSON. They have a fine day care center. I mean, this sounds like an advertisement. It sounds like Amway, but that is not what it is.

They have a day care center at 55th and Grays Avenue, and I went over there a couple of years ago when they opened it up, I guess, originally. They service a lot of children from public housing, from Bartrum Village that I know personally. It is a quality place, it is clean. I mean, that is the first thing in my head, it is clean. And they have teachers there who are caring.

Last summer, I guess it was last summer, Ron invited me to go to their graduation, preschool graduation, and you could see the parents participating and the kids were fully involved. They said their little plays and their little pieces, you know, like they do, but it was a good, wholesome family environment.

So you get two things there. You get, one, you get quality medical treatment. Then on the other hand, you are able to put your kids into a facility where you know they are going to be safe and people care for them, and I think that is really important today. So if I had a kid 3 years ago, I would send them to the Grays Avenue center.

Mr. WILLIAMS. I am glad you brought those points out, because folks seem to find such difficulty in terms of health access, first of all, in feeling comfortable so they can get real health treatment, communication. The extension of that is really the family. If the family approach is not there, you are really not going to have service.

So here is an organization, a local organization who combines separate facilities whose philosophy and approach apparently is to

address the family and do those cogent needs, a model, I suppose, is just what we are always talking about and you have experienced that and your testifying is going to underscore that.

Mr. JOHNSON. Oh, sure. I mean, we could use more of that, Senator. No, we are talking about—I am sorry.

Mr. WILLIAMS. No, go ahead.

Mr. JOHNSON. If we are talking about saving our kids, then we have to talk about at 2 years old and 3 years old, as soon as we can get them away from Mom and put them in another environment.

Mr. WILLIAMS. So you are saying there really is no mystery on where to find models——

Mr. JOHNSON. No.

Mr. WILLIAMS. It is here, right?

Mr. JOHNSON. Well, it is right there.

Mr. WILLIAMS. And we didn't conspire this——

Mr. JOHNSON. Oh no.

Mr. WILLIAMS. I didn't know you were coming.

Mr. JOHNSON. I didn't know you were going to come.

Mr. WILLIAMS. I didn't know Ron was coming either. But you lay out a model which people who make policy always, can we find one?

Mr. JOHNSON. This was there.

Mr. WILLIAMS. And that combination is there and just happened to come out, so I really am pleased that you underscored that.

Mr. JOHNSON. Thank you.

Mr. WILLIAMS. I just wanted to ask you ladies, did you say you were in college before you got pregnant, Ms. Lockman?

Ms. LOCKMAN. Excuse me, I graduated from college.

Mr. Williams. Oh, you graduated.

Ms. LOCKMAN. Yes.

Mr. WILLIAMS. You had graduated?

Ms. LOCKMAN. I graduated—no, I got pregnant in my last semester——

Mr. WILLIAMS. OK.

Ms. LOCKMAN. [Continuing]. But I did graduate.

Mr. WILLIAMS. So you now have your degree.

Ms. LOCKMAN. Yes.

Senator WOFFORD. And then you lost your health insurance, if I understand.

Ms. LOCKMAN. I lost my health insurance. As soon as you graduate, once you graduate, I am off my mother's plan. My mother had a plan with the school district. I graduated from college. I couldn't afford to keep the plan.

Mr. WILLIAMS. OK. And Ms. Bey, you are presently in community college?

Ms. BEY. Well, I took the semester off because I am in the process of moving, but I——

Senator WOFFORD. Well, what I was trying to figure out is whether you had your substance problem before you entered community college or whether you had it afterwards.

Ms. BEY. No, after I completed treatment was when I enrolled in college.

Mr. WILLIAMS. OK, thank you.

Senator WOFFORD. I want to second what Senator Williams said about models. We are looking for models in terms of national health legislation and what we should support, but I am tired of having models and pilot programs that never get expanded to deal with the whole problem. The purpose of a pilot is to ignite the furnace, and if I have any effect in Washington, which I hope to have, it is to take some of the pilots that are working and ignite the whole so it gets to everybody.

Mr. STARR. May I comment on that?

Senator WOFFORD. If you would identify yourself.

Mr. STARR. Phil Starr, Southeast Lancaster Health Services. I am also affiliated with Covenant House and Greater Philadelphia Health Action. It is also a nonprofit community health center.

The book "Within Our Reach" by Schorr and Schorr documents what the models are. We have the knowledge. It is a question of whether we have the will and whether we want to spend the money. It is not a question of models. The models exist. It is a question of whether we want to do it.

Mr. JOHNSON. You are going to spend the money now or you are going to spend it later, there is just no question about that in my mind.

Senator WOFFORD. The court reporter who is doing the transcript, which our committee is going to make good use of, needs to get anyone who speaks on a microphone or the court reporter can't get it, I am told. So if you maybe would see the court reporter and make sure he got your comments, including the name of the book again, what did you say?

Mr. STARR. "Within Our Reach".

Senator WOFFORD. "Within Our Reach".

Mr. STARR. By Schorr and Schorr.

Senator WOFFORD. By Schorr and Schorr.

Mr. Heigler, Ron Heigler, I congratulate you too for your work and also for being with us in Harrisburg as well as being here today. Let us find the pilots and then ignite the whole——

Mr. WILLIAMS. I do want to say, though, that the book approach is only one approach and there have been some problems, at least within some minority communities, where people just refer to the books and they leave out a whole host of operative people.

So I am sure it is all well-listed, but I just want to comment, at least from my standpoint, that I don't think we ought to limit ourselves to the book by any means, and that in the past has caused problems because those who write books are the same people who benefit from the system as it is. So I would caution that as a unilateral approach, Senator.

Senator WOFFORD. And I would add that much as I think a hearing like this can be helpful and it is very valuable for you to come and give us this testimony, I and others who are involved on the Washington front, just as those who are involved in Harrisburg, need to go and visit the site and see the programs in action, and I look forward to doing that.

Senator WOFFORD. Frederic Kauffman, would you talk to us for a few minutes about the other perspective, because you are Director of the Emergency Department here at Temple and I would like

to see how your experience compares with the stories you have just heard.

Dr. KAUFFMAN. Senator Wofford, Senator Williams, distinguished guests and members of the Temple University family, good morning. My name is Dr. Frederic Kauffman. I am an Associate Professor of Medicine at the Temple University School of Medicine and I am the Director of the Emergency Department at Temple University Hospital.

Seventeen-thousand patients a year are admitted to Temple University Hospital. Thirty-six percent of those patients arrive via the emergency department. Temple is a level one trauma center, and 59 percent of the trauma cases seen at Temple are related to homicide. In addition, more indigent and trauma care is delivered at Temple University Hospital than any other institution in the Commonwealth of Pennsylvania. It should also be noted, though, that Temple also serves as a heart transplant center and is the fourth-busiest heart transplant center in the country.

Last fiscal year, Temple delivered $12 million in free and under-reimbursed health care, and as such, under the Medicare system, Temple has been designated as a super-disproportionate share hospital and truly serves as a safety-net hospital providing care to the underserved patients of North Philadelphia.

My principal purpose here is to address with you the impact on our emergency department when primary and preventative care fail in the community of North Philadelphia. The challenge of emergency medicine carries with it very heavy emotional and physical stress, primarily due to the unpredictability of the nature of the demands for our service.

Inner city violence, problems of substance abuse and poverty often result in patients being brought to our department in rapid succession and requiring the emergent services of many subspecialists throughout the hospital. Patients with gunshot wounds to the head, with baseball bat beatings to the head and to the chest and the extremities require very sophisticated specialty care if they are to be served properly.

In addition, however, inadequate primary care and inadequate preventative care results in its own set of medical emergencies. The 8-month pregnant patient who abuses cocaine presents for the first time to the medical system in our emergency department bleeding and in active labor. She suffers from a complication of cocaine abuse known as placental abruption and she requires the emergent services of the obstetrical department if both she and her premature infant are to survive.

The elderly patient with a history of hypertension who does not have proper primary care and has poorly-controlled blood pressure arrives in our department with a devastating stroke that could have been completely prevented with adequate primary care of the patient's underlying medical problem.

While these emergent cases are being taken care of in the emergency department, our waiting room is filling up with patients who have less emergent needs, for in essence, inner-city emergency departments run two types of practice. The first is the acute emergent care practice, but the second is a primary care practice that is of necessity due to a lack of patient access to the system, due

to the lack of quality medical care, and at times due to the lack of patient understanding of the medical system itself.

So the question arises, what is needed to address the care of the nonurgent patient? Clearly, it goes beyond having adequate numbers of primary care physicians. Timely access is necessary, and that must be access to quality medical care, for access without quality is really a medical charade and patients who have access but do not receive quality care will certainly end up back in our emergency department.

Temple has sought to address the issue of the difficulties of primary and preventative care in North Philadelphia through many different means, two of which include the following. One is the TIPS program, which is a program that was established with the help of the William Penn Foundation, and it serves as an outreach to pregnant women early on in their pregnancies, women who have high-risk pregnancies for whatever reason. The hope is that through aggressive in-house and also in-hospital service, that these patients will go on to deliver healthy babies and the hope is that we will prevent the devastating infant morbidity and mortality that is presently occurring in this part of the city.

Second, Temple has worked to establish a primary care network through its relationship with the Health Partners of Philadelphia, which is a managed care delivery system to medical assistance patients in this area. Health Partners of Philadelphia serves over 50,000 patients through a program of quality interaction between the hospital network and the primary physician network in the community.

So to summarize, I think it is very clear from my standpoint that a lack of primary care and a lack of preventative care has a very major impact on Temple's emergency department.

Second, the problems of inner city violence, drug abuse, and poverty clearly, in my mind, have a major impact on the emergency department and the health care system in general and must be addressed in any health care proposal if quality care is the ultimate hope. No amount of primary care in and of itself will eliminate this need.

I am concerned also that proposals that are in existence that propose to reduce medical education funding will potentially impair the ability for places such as Temple to deliver quality medical care.

And finally, I will say that community primary care must have several components if it is to be successful. There must be adequate numbers of physicians, there must be timely access to care, quality medical care must be delivered, and any program that is established must be tailored to meet the needs, the very individual needs, of the patients that it serves.

Thank you.

[The prepared statement of Dr. Kauffman appears in the appendix.]

Senator WOFFORD. Thank you. Can you say anything about the degree to which violence has increased as a health problem that you have seen in the hospital? Is it increasing? Is it about the same level?

Dr. KAUFFMAN. I have been at Temple since 1981, and just when I think I have seen it all, something else comes in. I think it is very clear in my mind that violence is increasing, that there are a number of reasons for that. Probably the most important reason is the problem of substance abuse. But certainly from where I stand, violence is something that we observe every day and I think, from my standpoint, it is clearly on the rise.

Senator WOFFORD. Have you seen health problems for other people than those that suffer the violence, the children who witness it? Maybe the emergency room isn't the place where you would register it, but it occurs to me it must be like a ripple effect that affects a lot of other people, emotional problems of a serious nature.

Dr. KAUFFMAN. Absolutely. I think that that sort of problem comes up in many different ways. It comes up with the 12-year-old child who is caught in crossfire and comes in as a gunshot victim. It comes up in situations where a 17-year-old is killed because of the violent nature and the family is totally devastated. The teenager was totally healthy, totally well, and in a split second is taken away from the family.

We see it from the standpoint of the emotional impact that the violence has on the families and friends of the people that are involved. So clearly, I think, there is very much a ripple effect.

Senator WOFFORD. Mr. Johnson, did you want to comment on that?

Mr. JOHNSON. I would just like to say that in terms of this violence piece, I would hope that we would look at how mental health services in this country are being delivered. Most people are resistant to seeking mental health services. I am almost resistant to talking about it.

If you are a 2-year-old who grows up, let us just look at the worse scenario, who grows up in a violent household and then you live in a violent neighborhood and then you see it all glorified on TV, what you think is glorifying it on TV, on the news, and the cameras in your neighborhood, and now the violence in the schools, and all you hear and see and sleep and eat is this violence that is out of hand now, then it just seems to me that we need to be working toward deprogramming those kids and reprogramming them. I mean, that is how I say it.

We are resistant to it. A lot of folks, in at least the African-American community, are resistant to mental health treatment because of all the reasons, because you don't want to be labeled as crazy.

So as well as on the medical side, I would hope that we would be looking at the mental health side. Anytime an HMO can make a profit out of the money it receives from the State for mental health services, it means people aren't using them. So I would hope that because violence is now a public health issue, that we would be looking at the way quality mental health services are delivered to our families.

Senator WOFFORD. Senator Williams.

Mr. WILLIAMS. Doctor, you spoke a lot on the violence as a health issue. I suppose that you as a doctor do believe that violence is a significant public health issue at the present time.

Dr. KAUFFMAN. Yes sir.

Mr. WILLIAMS. OK. Among your peers, have you come to any determinations as to why that is so, over and above the fact that drugs are prolific? I guess to break it on down, has there been in health circles or medical circles any inquiry into the mental health or psychological aspect of that phenomenon?

Let me put it in this context. This book by Steven Fox called "Blood and Power" where straight out with all the facts and figures laid out, the Italians, the Jews, the Irish blasted their way through organized crime into respectability in the country. It is all laid out in facts. That therefore was violence by all these underclass, underprivileged, immigrant kind of minorities, so that essentially in modern America, groupings have used violence to get into respectability, and the vestiges are still there in organized crime. And they speak about minorities doing that too. They thought minorities would do the same thing except certain things didn't happen.

Given that as more or less a natural phenomenon into success context, is there anything different in the psychological approach that the phenomena now exists in?

Dr. KAUFFMAN. Yes, I think I would refer to your concept of violence leading to ultimate respectability. The violence in the inner city is out of total disregard for human life. The concept of respectability has to do with your standing within perhaps the illicit drug trade trafficking in your particular community or your standing from the standpoint of the material things that you have been able to gain through that practice.

I think what is different, though, is that there is no common good that is even conceived of within the violence that we see. What impresses me so much on a day-to-day basis is the total lack of regard for human life.

Mr. WILLIAMS. I guess that is what my bottom line is too, and I just wondered out loud whether the medical community, the health community, as resourceful as it is, has said, look, fellows, let us take a look at this. What is this all about? I wondered whether among your professionals there is any inquiry going on, any subconclusion, any conclusion.

I will tell you this, within the active, at least black community and Latino community as well, it is very clear that the value for lives in the minority community is not as high as others across the board among minority people and majority people as well. And given that lack of value for whatever reasons, that is in the mind of the "violentor", and basic people talk about that every day.

We just wonder, I guess, out loud, and you probably take 100 people in the minority community who know something that is going on, probably 75 would say that, and I just wonder whether the professional community who comes along with solutions have yet caught up with that phenomena or whether it is something that is resisted in the health community.

It is staggering to wonder, whether it is in a jail in Mississippi where 31 people get hung or whether it is Rodney King, all those things across the board, or whether it is blacks-on-black crime, all exhibits a condition that says the value of that life in somebody's mind, whether it is a black person's mind, is not as much. It seems to me that is a health precondition that I would wonder whether the medical or health community is yet asking itself.

Dr. KAUFFMAN. I think, from my perspective, and certainly not knowing everything about the literature in medicine, I don't believe that the medical community has quite come to that point yet.

Mr. WILLIAMS. I think you are right.

Dr. KAUFFMAN. That would be my own perspective. I think that the perspective of the medical community, the emphasis is more on the study of the violence itself, how frequent is it, and how do we in the hospital or health care setting make sure that we are properly protected. I think that is where the emphasis is now, but I don't believe it has gotten to the——

Mr. WILLIAMS. I appreciate your candor about that.

Dr. KAUFFMAN. [Continuing]. Gotten to the point that you have addressed.

Mr. WILLIAMS. But just put in your mind that indeed, even within your profession, there are a number of your professionals who think the same way who don't find a need to put it on the table because it just would not be conceived of as something is relevant or even existed, but there are a number of people who talk to us, the black or Latino community, who are health professionals or medical people who could put that on the table as a scientific plus toward moving toward the thing that everybody talks about as a subject. I just wanted to make that point.

Senator WOFFORD. I want to thank this panel very much.

By the way, there was hearing last week of our Labor and Human Resources Committee in Washington on youth violence, and I will try to get the testimony for Senator Williams and others of you who are interested. Marian Wright Edelman and Deborah Prothrow-Stith testified very eloquently and vividly, and it is a subject we are not going to escape and we had better face it and see how it fits into the legislation that is needed in health care.

I hope to keep in touch with you as we move forward on this.

Ms. Bey, did you want to add something?

Ms. BEY. No.

Senator WOFFORD. Thank you very much.

Ms. BEY. Thank you.

Ms. LOCKMAN. Thank you.

Senator WOFFORD. You have made a real contribution.

If John Thomas, the legislative aide to Councilwoman Marian Tasco, would take the place of the panel, I will introduce him to read part of Marian Tasco's testimony in a few minutes.

We will have written testimony from Representative David Richardson, who has given real leadership in the State legislature on this subject, and as Chairman of the House Health and Welfare Committee is going to be playing a key role there.

[The prepared statement of Mr. Richardson appears in the appendix.]

Senator WOFFORD. Right now, I would like to introduce Senator Hardy Williams. Senator Williams is a true son of West Philadelphia. I appreciated your joining me in the questioning here, and I appreciate your being here instead of heading to Harrisburg, where you are also due today.

Mr. WILLIAMS. Not now, they have called it off.

Senator WOFFORD. They have called it off. Good. We are the beneficiary of that.

Despite what he said a little while ago about books, Senator Williams is not only an outstanding political leader and athlete but he is a scholar, but one who has changed the face of politics and government in Philadelphia. He was an honor student at West Philadelphia High School—I want some of this in the record. I know a lot of people know all this, Senator Williams. He was an honor student at Penn State University. He was the first African-American player on Penn State's basketball team and went on to captain the championship teams of the early' 50s.

He returned from service as a First Lieutenant in the Korean conflict and went on then to receive his Doctor of Jurisprudence in 1952 at the University of Pennsylvania. As a practicing attorney, he distinguished himself in precedent-setting cases, earning the respect of the legal community.

He was not content with his own success. He has organized citywide grass roots campaigns for other African-American candidates. He paved the way through his own candidacy for mayor of Philadelphia in 1971 for African Americans to the State House and Senate, the mayor's office, and the Congress of the United States.

As a legislator and a Senator, Hardy Williams has been a champion of society's most vulnerable members: youth, senior citizens, and the poor. His special interests and leadership on public health issues have led to his chairmanship of the Senate Public Health and Welfare Committee. He also chairs the Philadelphia Senate delegation and serves on the Judiciary, the Rules and Executive Nominations Committees, Appropriations, Finance, State Government, and Veterans Emergency Management Affairs Committees, and on the State Planning Board, the Governor's Advisory Commission on African-American Affairs, the Governor's Task Force to reduce welfare dependency, and the Cheney University board of trustees.

Senator Hardy Williams.

STATEMENT OF HON. HARDY WILLIAMS, STATE SENATOR FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. WILLIAMS. Thank you, Senator Wofford, and good morning. I, too, want to congratulate you for bringing these field hearings to Philadelphia and in particular to address the health issues and needs within the urban community settings.

I also want to say the last issue we talked about, the youth violence issue, is one that has been very close to my heart for over 25 years, and indeed, if you look in the record, we probably had the most in-depth study and success in that youth violence problem here in Philadelphia, and following the approach that the scientific community, like doctors, do, you look back and you see what was done. Doctors never do that, of course, when it comes to strange subjects like this, but youth violence in Philadelphia had impact, cause, effect, solution, the whole thing, and that is on record.

So when you say I should read that testimony, I should probably provide you with some testimony because I grew up in Philadelphia on public assistance, in gang warfare, and that issue never left me from that point all the way through school, college, politics, and the like. It is a very keen expression of the same question of violence as why environmentally for it to be recognized now as a public

health issue is not at all strange to those of us who were back there then, when you couldn't go to school because the whole community was locked in it. That was the black community.

Well, of course, it has split itself. The factors are different, but the thing is the same. So I just wanted to express that particular thing.

I would like to make the heart of my remarks basically politic, public policy input, if you like. I assume the public health diseases that are significantly high in the minority and black and Latino communities, such as AIDS, infant mortality, and the like, all of those things, it is an absolute shame that the country, the city, and the State could let that exist and not, say, adjust it as a scientific matter, a resource disposition matter, and a moral matter. That is what it is. It is just a shame, and North Philadelphia is a national disgrace in regard to that. To think that that can exist and we just shuttle along talking about cost containment, managed care, is ridiculous.

Therefore, I assume that you know that access is a code word, access. Access means racism too, in the sense that if I am talking to a Latino and I am Caucasian and I don't work hard and I am a doctor too, because most doctors don't work hard to understand patients in the first place, and doctors will tell you that. So if you double that with the way that minorities are looked at anyway, then access is not just a matter of language but cultural orientation on both sides.

And I don't mean harsh racism, but people just don't care as much for an old black man, because African-American men aren't even included on the chart. Let us face it, they are not on the chart. And yet on the other hand, we are talking about violence in America. Come on. How did those youngsters ever get there, and what happens to those who go through when they are old, never on the chart? That is a cultural lag in the bureaucracy that repeats itself.

In other words, if our problem is universal access or whatever to health, and if you don't include the bureaucratic, the cultural, and the other factors that you don't get access, if you don't include those, all you are going to do is take a bunch of poor people, give them another system, spend a lot of money, and still not provide health.

And so when I was interfering and saying that Mr. Heigler's organization is a model, it is a model. They have been discovered. They have been discovered, but not really because there are a lot of groupings like that.

Therefore, what I am saying is you take from President through the Senator all the way down to the local medical director, Philadelphia medical commissioner, I am sorry, mayor, State, all that money and all that energy and we are talking about a poor community, an urban community. Unless we fully understand as scientists all of the derivative factors to analyze and diagnose the problem, you are going to push more money into hands that are going to dependently look at the field, and we will run these programs.

In other words, there is going to be billions of dollars in the health field both ways, mainly in white hands, and I am not talking about white as color, I am talking about if you are going to

have the problem here and this here, you are going to have to include those people in on the economy. You are going to have to include a lot of people who know more about that than someone else so you can have access and communication.

You are going to have to discover the models, because in North Philadelphia, Peter, you have Dr. Lingham and the Quality Health Care. They were talking about her. Ann Pastor should be supported. The TIPS program, that is great, but that is community-based, up from the ground like Heigler's organization. And so we have to begin to empower.

You know, in South Africa all this stuff is going on, they are negotiating. Hopefully they are coming to reality. That is to say, then, when you have the class in power, you repeat the same mistakes. You don't solve things. But if you begin to work it out, you have a different kind of mix. That empowerment has to start.

That is to say, we always find it difficult, well, how do we choose? Do we choose Reverend Baylor? We ask Peter, who is president. Well, come on, I am elected, so ask me first. I might be a dummy, but ask me first. Just follow the rules, and then hopefully there are other ways to get to the community where you see what is going on is a mix of—well, let us just take managed health care. That is the issue in the country, in the world. Tons of money, first of all, largely all on poor people like in North Philadelphia.

And I will tell you, Senator, there is little or no inclusion of minorities in that conversation, at all levels. How ridiculous. And you are talking about poor people, and you are talking about access, and you are talking about preventative. How can you prevent something you can't even talk to, you can't even get the people in the room?

So all I am saying is if you take that noninclusion and take that general role and you don't correct it, and the biggest issue going on at the city, State, and Federal level is managed care, managed competition, and the like, and our challenge to you, Senator, and every other bureaucracy is to demonstrate a significant inclusion of African Americans, Latinos, a large percentage of the people who are going to be the guinea pigs or the participants.

So my plea is that on the very subjects of inclusion and the weakest and frailest of groupings, groupings who should be included in the policy and the economics, and if that kind of a partnership can significantly come about, you certainly are going to have a better quality of care.

I was not surprised at HMA in Philadelphia, a managed care facility took over from another organization that failed, because they had some understanding. People think, well, there is just the approach to save money. It wasn't just that. They know something about the constituency they served, and no one yet has said, well, gee, what is that expertise? Let us check it out. And unless we are very careful in all the other models that are on the drawing boards, some people just rush in to make money. Making money is fine, and cost containment, but delivery of service is it.

I am just saying that the major factor in the new health care issues affecting poor people is the noninclusion of ethnic and cultural groupings in the participation and the provision of expertise in

same. There are a lot of reasons for that, and hopefully the groupings that are now at least talking will insist that that change.

But as you are conducting these hearings in the urban setting, managed care being the biggest factor that is on the drawing boards, that recognition will also affect the things that exist now like the high significance of the public health diseases in minority communities, that if you look at it not just in a cost way but in an epidemic way, we have got to solve those problems.

One last thing in terms of that, the violence as a health issue, no one knows how that cuts. Lots of people live with it. Dr. Kauffman indicated what it is like to come into the emergency ward. Well, what is it like to go home at night from work and to know that the possibility that that kind of violence is going to be near you 100 times more than the person you work with? That is a health condition.

Now if you follow me, stress is a very important factor, and it used to be that you guys didn't even think that could help deal with cancer, but today you are sort of changing your minds. And in my estimation as a common sense person, it has always been that stress covers everything, everything. And that violence thing is not just on that family but whole communities who are there every day, back and forth. I am saying that the value of the life there in those communities is the key factor on how we as a society coordinate to deal with it.

The reason I asked Dr. Kauffman that question was professionally, I want to know—that in many cases is a black problem in the city. I want to know how many white doctors think about that, what their kids would be like, as a scientific matter, and therefore begin to look at it as a scientific matter.

Dr. Ross, he may not say anything, but he goes home and thinks about that every night because his friends tell him all the time and his kid might have to go here and there. It is a different think from maybe someone else.

So I am just saying that that medical and health community has to be challenged, and some of the research dollars, Senator, have to go into that, to the honest, real things. Someone has to say, OK, well, what is this value of life that people are always talking about? There are a lot of black people who say, well, they don't value black life and people dismiss it as, don't talk black and white. Well, come on. Come on, let us be honest about this. Where are people dying and why? And someone scientific has to give us that answer. So I am saying, let us track policy, our questions, and our moneys to the same place, if we are going to use that for all these other things.

I think that that pretty much sums up a tone where I wanted to put on the table the policy of inclusion connected with the promises of success stepping through universal health care for everybody, stepping through managed health care and all those new things.

And I tell you, I tell you right now, it is woeful on the local, not that Dr. Ross isn't trying like hell, but it is woeful on the local level. He has to fight every step of the way to get a program like that. On the State level, it is poorest, it is the same way.

And on the national level, Senator, I am glad you are here. You guys can push buttons and kick butt, and when you do in terms of that, things follow. So there is need for legislation, whatever that is, to say, let us tighten this up, let us adjust this so we can't avoid these basic things. Let us be able to program what we get for the money we spend in the areas that we put up as challenges, violence, managed health care, access, barriers. You know, let us be real.

So again, I want to thank you for the opportunity of making a plea for a coherent and inclusive national health policy that hopefully will dribble down to the local bureaucracies who otherwise would handle it in accordance with their own values.

Senator WOFFORD. Thank you.

Well, you have made a point that can be applied at several fronts of our problem. One place where I will remember well is as we craft the legislation that is likely to lead to regional purchasing co-ops for health care, which would provide health care to everybody in a community, is that co-op needs to have the principle of inclusion written very strongly into its charter and then to have follow through.

I would be interested in your thoughts, once the President's task force has given us some beginning structure and language, for you to look at it with a good, sharp eye to see whether the legal provisions call for coherent inclusion at the local level and then the procedures by which we follow through.

Mr. WILLIAMS. I think the co-op is a good idea. I also think that there are, for new models or new initiatives, and also an opportunity for inclusion of a lot of ideas that could be generated by some people. I would be glad to be included to tender some suggestions. I am sure Dr. Ross, people like him, and Ron Heigler, I know people who could help.

There are loads and loads of very bright, gifted Philadelphians. We probably have, per capita we might have the worst infant mortality thing, but we have probably per capita the brightest, most gifted, the most committed group of African Americans in the country going wasted, never pulled together to put input into policy. It is also a notorious and ridiculous condition.

So if you are inviting participation, I would be glad to get together a group that could make input to you on new initiatives, new models over and above the cooperatives and whatever that would tend to bring about the kind of thing that I was talking about, that I think would serve this country immeasurably.

Senator WOFFORD. Indeed, I would welcome that.

The idea of a purchasing co-op for health insurance in a region is that it would negotiate with the networks and the options in that region. So my point about inclusion was that the purchasing co-op itself must be inclusive in its structure and its membership, and second, it has to have that principle of inclusion as it negotiates, encourages networks that will offer various options to people.

Mr. WILLIAMS. Sometimes people talk words, inclusion, it is generality, but when it comes right down to it, the guy who is in charge, he goes around it. We have to watch out for that. Otherwise, it won't happen. It will be lip service.

Senator WOFFORD. Nor do we need to wait for any new structure of a regional co-op to begin to do on a better scale what you are talking about, so I would welcome coming back and meeting with whoever you want to bring together with me.

Mr. WILLIAMS. Absolutely.

Senator, I wanted to introduce Ms. Virginia Leemus, to my right, who is a member of my staff working on health issues. Ms. Jean Thomas did not make it today. Ms. Thomas has been an expert for many, many years in the public assistance and health area as well, delivery of services, all services, the public assistance of clients. So she is not here this morning, but both these ladies represent the minority and poor communities that I was talking about very well, so I just wanted to make sure you met them.

Senator WOFFORD. I look forward to learning from you and working with you.

We do have a Thomas who did make it, not a doubting Thomas, but Mr. John H. Thomas, Legislative Aide to Councilwoman Marian Tasco, and he is going to read part of her testimony today as she is trying to get back from Buffalo.

Mr. Thomas.

STATEMENT OF JOHN H. THOMAS, LEGISLATIVE AIDE TO COUNCILWOMAN MARIAN TASCO, PHILADELPHIA, PA

Mr. THOMAS. Good morning, Senator Wofford. I would like to again welcome you to Philadelphia and to Temple University, my alma mater, as well as Councilwoman Tasco's alma mater.

Councilwoman Tasco is a member of the Philadelphia City Council as well as the chairperson of the Committee on Public Health, Human Services, and Recreation. I am pleased to appear before the U.S. Senate Committee on Labor and Human Resources in its formal field hearing to present testimony.

I will attempt to address the topic, solving the urban health care problem, the role of prevention. In a city where health care is our most important industry, Philadelphia is one of the meccas of medical technology and advancement, and yet our urban population has not consistently been a beneficiary of this extraordinary capacity to diagnose, treat, and control, if not cure, most health care problems.

We are embarking on a search for a national health plan, as we should, because for too long, health has been interconnected with wealth. There are economics of health care that I will not venture to discuss, but Councilwoman Tasco's exploration of Workforce 2000 themes have reflected her concerns for self-sufficiency issues.

It is appropriate for the Senate Labor and Human Resources Committee to take testimony on health care because the lack of jobs and training has directly contributed to homelessness, substance abuse, and an array of mental and physical health problems, but I would like to suggest to you that greater than the connection between health and wealth is the connection between health and hope.

There are studies, for example, that have confirmed that when black students in New Haven, CT, raised their academic achievement levels, they experienced validation through self-discovery. Their new-found talents and increased self-respect affected even their families, and it was found that the overall health of the com-

munities improved. Dr. James Comer at Yale University conducted the study.

Let us begin by asking, what is the urban health problem? I say to you that the problem of urban health care is a lack of hope. You know that the urban population is minority, poor, uneducated, and uninsured, underinsured, or unemployed and uninsured, and more than likely underserved. In the final analysis, most of them have no reason to take care of themselves, either don't know how or cannot navigate the health care system. Why should health matter to them?

It is not only a question of access, it is also a question of attitudes. We all know that this is not just a local problem, it is a national problem, and precisely for that reason it is right for Federal intervention. And where the Federal government has intervened, we have found creative and responsive programs.

Our most recent and best health programs have been developed through local, State, and Federal collaboratives. Quite clearly, they are models for other local and State governments to follow. What has been fundamental is that we have developed a new model for the delivery of services. I believe that the basis is education, outreach, and hope.

This is what we have witnessed. The programs have been taken to the communities that they serve. Professionals have extended themselves to provide information, services, and activities for the prospective patients. Then they have listened to what these patients say they want or need. And finally, they have empowered these same patients to participate in their own care. Such approaches create hope by showing communities what opportunities await healthy families.

Education, outreach, and hope are the cornerstones on which we can build prevention, and they are the answers to solving the urban health problem. We have programs that prove this.

The first program is the immunization initiative, whose objective is to immunize 90 percent of our children by age two, because many of our children were not immunized by age six. The project has mobilized private doctors, hospitals, and clinics to monitor every child that comes in contact with a health care professional.

The second program is Healthy Start, whose objective was to address the infant mortality, which in Philadelphia approaches third world levels. The goal is to guarantee optimum prenatal and postnatal care for newborns by engaging mothers within their community of the assistance of community support.

But after Healthy Start, we need more Head Start. Then we should also consider something called Another Start, for those children who have been exposed to abuse, neglect, violence, and drugs. These issues will also respond to a model of education, outreach, and hope.

The third program, BEBASHI, which stands for Blacks Educating Blacks About Sexual Health Issues, has used this model and combined the mobilization of health professionals with community outreach. It has singularly done more than any other program to educate African Americans about AIDS.

I can envision another program which can be developed and implemented along these lines. The community explores how it bene-

fits when members are healthy, productive, and happy. Furthermore, the community demands that health providers have a vested interest in their individual physical well-being, so the process already exists.

Now Councilwoman Tasco requests that you, Senator Wofford, and all the members of the Senate Committee on Labor and Human Resources, that you use this model of education, outreach, and hope in a collaborative model between local, State, and Federal agencies to address three major problems among urban residents: heart disease, diabetes, and cancer.

Further, she wished to invite the committee to implore the same strategy used to develop Healthy Start by devising a national competition to create programs to address women's health issues around family planning, heart disease, and breast cancer. The philosophy of all these programs must be to build on the culture of the community that is being served and to empower the members of the community to help themselves.

Another example of this is the Philadelphia Black Women's Health Project, where women are helping other women to realize their physical, mental, and spiritual potential.

Finally, I would request you to support the Congressional Black Caucus legislative agenda which addressed most of the concerns of urban centers such as adolescence health projects, research on obesity, medical coverage for mammographics, pap smears, and grants for medical and health care graduates who serve economically-disadvantaged communities, and Medicaid coverage for substance abuse treatment.

Thank you for your attention.

Senator WOFFORD. Thank you.

One question to both Senator Williams and to you, Mr. Thomas, to what extent do you think school-based clinics can play a useful role and should be expanded? That is one of the ideas that is being pressed.

Mr. WILLIAMS. I think that the schools as institutions have really, for some reason, worn out their usefulness, not that their capacity is not great, but their level of thinking is traditional and not expansive. So presently, I think that at least in this community, newer and more creative models that are community based are a lot more productive, only because the change is hard and school systems are just like politicians, they are hard to change.

Otherwise, it would be great for that in terms of capacity, and especially if it would build in a community involvement piece which they are reluctant to do because they just have that ingrown reluctance. That is my observation. As institutions, it would be great, but I think that the bureaucracy is sort of stuck in a rut.

Senator WOFFORD. Has there been progress in the West Philadelphia schools? A few years ago, the West Philadelphia Improvement Corps started with the idea of the schools becoming more neighborhood community centers in which the facilities were used by community-based groups for after-school and Saturday work and——

Mr. WILLIAMS. Senator, let me tell you about that. When I was young, that is when we did it and that is the way it was. It was very, very vital. That is the way that it was. That changed, so that today—and really, there was some effort to do that. It is really no-

where near what the rule was. And very frankly, some of the efforts that were pointed in that direction, they are good efforts and some programs have been terrific that Penn has been involved in and the like. And I have always said, well, what are you guys doing, because it can't be as good as it ought to be.

So I think there are some good programs, but some people run it sort of close to the vest as well so that there is a new order coming in and it is crazy. There is some good stuff too, but if you don't lock hands with some of the old war horses that are there doing the same thing, still doing it, what you are doing is just ignoring and disrespecting order.

So the capacity is there, I think, in West Philadelphia. It is nowhere near what used to be a viable, enlightened, wide open, very creative involvement of all the communities, so we have a ways to go.

Senator WOFFORD. What about this——

Mr. WILLIAMS. That is why President Leacoris is sitting here as well. The universities in this city are far, far, far from the input that they can make on the communities we are talking about and health in systems. It is almost like a closed door. Temple is an exception, but whether you are talking about Harmon, Jefferson, Penn, it is ridiculous. Their educational institutions, whose mission is education, and what we are talking about, Senator, really is education and access, and for some reason they are afraid to lock hands as well.

I have chided them on that, and while we are talking, I think for you as another avenue to get them down to some level of reality as well. Not that universities don't participate, but it is a throw in the bucket compared to how it could be.

Senator WOFFORD. This drive for universal immunization, or Mr. Thomas said 90 percent vaccination, I am not quite sure why our goal shouldn't be 100 percent, but how far do we have to go and how well organized is that program? Are there any lessons from Philadelphia's progress or problems that would apply to the current planning for national immunization, universal immunization that the President has proposed and that is part of the health care task force assignment?

Mr. Thomas.

Mr. THOMAS. Senator Wofford, I am sort of standing in for the Councilwoman. I don't think I am really qualified to address that. But I think when Dr. Ross——

Senator WOFFORD. Dr. Ross may.

Mr. THOMAS. [Continuing]. Comes up next, he probably can address that more fully, having studied that.

Senator WOFFORD. Well, I, for one, am for universal immunization. I know it saves $10 for every dollar you invest in it. That has been the estimate by a lot of people. But it isn't even the cost. It is what Senator Williams refers to as a moral fact, it seems to me, that the United States should have universal immunization of children. Most major other countries do.

In the Netherlands, at birth you are given a schedule, your parents are given a schedule of the immunization needed. At the set date, it is followed up by a notice. It is then followed up by a visit, and they in fact have sanctions in the Netherlands and they get

99-point-something universal immunization. There must be a way for us to do it in this country.

Do either of you want to add anything? I appreciate greatly your testimony.

Mr. WILLIAMS. Yes, while you are talking about that, Senator, I was just thinking what managed care is all about, and if we could just relate that to families. When you are talking about universal immunization for children, it sounds like the children are isolated from families. It very well may be that those points of contact can be a program of other points of contact early on for all the problems you talk about that come later on.

If we are talking about managed and preventative, it seems to me if we are interested enough to identify children, who are going to be nothing but grown-up children when they get to adult age, then if you are going to touch them for any point as a program, why don't we touch them for all those basic points?

Now I am not going to discuss what those points should be. We are talking about violence, we are talking about security, we are talking about family. You know, if you immunize the child whose father is not working, when then may go into drugs, then you have an immunized child who grows up in a drug household. But I am just saying if you are going to care, that is what managed care is all about.

If you professionals, Doctor, are talking about prevention, I am just saying unilaterally we can do good programs and we can tie that into some other kind of family oriented approach.

Senator WOFFORD. I think we are in your debt for giving us a strong, better definition of the word "care" in managed care.

Mr. WILLIAMS. Thank you, Senator. I appreciate that. I want to think I did some work today.

Senator WOFFORD. If you have more time, you are welcome to join me over here.

Mr. WILLIAMS. Thank you so much, Senator.

Mr. THOMAS. Thank you.

Senator WOFFORD. Thank you very much.

Our third panel, if they would join us, consists of Shelly Yanoff, Robert Sorrell, and Robert Ross. Dr. Ross is Commissioner of Health of the City of Philadelphia. Mr. Sorrell is Executive Director of the Urban League of Philadelphia. And Shelly Yanoff is Executive Director of the Philadelphia Citizens for Children and Youth.

First, Shelly Yanoff, the Director of Philadelphia Citizens for Children and Youth currently. She has done many things in this city. I have been on the track with her. She has invested her professional career as an advocate working on issues regarding child health and welfare and the common good of the Commonwealth of Pennsylvania.

Shelly Yanoff.

STATEMENT OF SHELLY YANOFF, EXECUTIVE DIRECTOR, PHILADELPHIA CITIZENS FOR CHILDREN AND YOUTH; ROBERT W. SORRELL, EXECUTIVE DIRECTOR, URBAN LEAGUE OF PHILADELPHIA, PA; AND ROBERT ROSS, M.D., COMMISSIONER OF HEALTH, CITY OF PHILADELPHIA, PA

Ms. YANOFF. Thank you very much, Senator.

I am glad to be here today to speak for a few minutes about children's health issues in Philadelphia as I see them as a child advocate. My comments have as their primary source the lessons learned in trying to assist thousands of children and their families secure health care and health insurance and assisting schools in providing eye treatment and glasses for hundreds of students who had failed the eye exams 1 year and a year later had not had any treatment, in watching families go back and forth between doctor, hospital, and lead-filled home with their lead poisoned children, in working on several city-wide immunization efforts, in watching hospitals discharge poor women and their newborns after less than 24 hours because the stay was no longer reimbursable, although socially, societally, and environmentally necessary.

The lessons we learned are that we do know a lot of things that work, as Elizabeth Schorr told us in "Within Our Reach", but that some things do not. We do know that what looks like a savings can indeed turn out to be very costly. We do know that if we as a society, State, country, or city are to progress in having families seek and practice preventive health care, we need to, one, make access easy and understandable; two, simplify the system and systems, treat family as a whole, and reject the systems that we currently have that require different eligibilities and providers for children of different ages; provide the public regularly with information about helping their children stay healthy; support this public and make it easy for them to act on what you have supposedly taught them; recognize that preventive health is inextricably tied to community health, something that Senator Williams was talking about earlier, that the tiny baby who is saved today in the Temple University Hospital by medical advances may in fact die within 2 months because of lack of knowledge, lack of support, lack of heat, lack of care, lack of hope; make the services available when and where the families need them.

There are many programs in Philadelphia which work which try to build on many of these principles. For instance, there are a variety of home visiting programs which serve about 1,200 babies a year. I think actually that is a little overstated, but that combines all of the program. These infants were considered medically at risk at birth. The home visits helped them and their mothers navigate through a difficult first year.

Particularly because of the short hospital stay, particularly because the majority of women giving birth in this city are the sole caretakers for their children, particularly because of poverty, drugs, and all the attendant ills, home visiting should be available and reimbursable for all the 30,000 babies that are born in Philadelphia every year.

Through this service, parents could be helped to learn to parent, babies could be assessed for early intervention and other appropriate programs, mothers alone would be less isolated and would be assisted in securing the help they need, and abuse and neglect would be prevented. That has been the experience in Hawaii, which is the only place that has universal home visiting.

The maternal and child health program provides support for about 14,000 women during their pregnancy. The program includes

the variety of outreach efforts which are both publicly and privately funded and provides good care to its patients.

The city's Healthy Start program in West Philadelphia will, I am sure, have a major impact, primarily because of its community-based, comprehensive, community-supportive components. But if we don't build the capacity to serve these families, if we don't expand our hours and sites throughout the city to make it easier for families to obtain preventive care, the health care will not be appropriately utilized.

In spite of many efforts, about 46 percent of our young children are not adequately immunized. Here again, we must make it easier. We must have the vaccine available, free, at private as well as public provider sites, and we must use neighborhood sites, schools, community centers, day care centers, churches, everything we can think of where children are so that they can be immunized. But we additionally must have the network to keep track of a child's immunization record and get in the touch with the parent, as you have just described occurs in other countries, or caretaker when the next immunizations are due.

As with all primary care for children, our clinics, both the cities' health centers and the federally qualified centers, should be open on Saturdays and early evenings. We must expand our efforts to go where the children are, where their families are, where and when they need them.

We currently do have three school-based clinics in Philadelphia high schools, one-and-a-half in middle schools, one is just opening, and one in an elementary school. There are plans to expand these efforts. They should be encouraged.

In the school-based health clinics in Philadelphia, Senator Wofford, the schools do not operate the clinics. They are contracted out to private providers. Many of them are operated by, in fact, the Federal qualified health centers.

We must be willing to provide our teenagers, additionally, with the information, support, and counseling they need to survive the threats of AIDS, substance abuse, alcohol addiction, and pregnancy. Again, we must make this information, support, training, counseling, and help available to them where they are to avoid what is known now as the new morbidity, the violence which threatens so many of them every day.

There are programs to provide young people with ways to respond to differences other than fighting, with assistance to get them through their teen years, and these programs should be available in every neighborhood in cities across this land. The Federal Government, the State government, the city government should reward and support the clinics, the recreation centers, the schools which take the services to where the children are.

We have several programs which demonstrate positive results in these difficult morbidity issue areas. We are learning more every day. But all the programs are small, they are all precious, they are not being what pilots should be. The Federal Government needs to maximize those.

In this city, as in many others, whole communities are being traumatized by the plague of violence. We need to look to develop programs to cope with the effects of that violence even as we try

to decrease its prevalence. Some of our schools have developed such programs, but our communities are primarily going it alone.

Last week, in a community meeting in North Philadelphia, a woman pointed to a child that she had brought and she said, he sits next to a child whose whole family has been shot in the last 6 months. There is no community effort to deal with the trauma of community that is being impacted by these negative, horrible events. What she said, and I want to quote it, it was so eloquent, she said, we need to put the community back into community mental health centers. I think that is a real lesson. It started out that way and it is not there.

A word about lead poisoning. About 65,000 children in Philadelphia are at risk of lead poisoning. The Centers for Disease Control, the American Association of Pediatrics tell us that all our young children should have annual lead screens. The city's laboratory, which processes an overwhelming number of lead screens, the overwhelming majority, is way behind and we are not screening two-thirds of those children now.

We have not been successful in Philadelphia, in Pennsylvania, in securing Medicaid reimbursements for home inspections in this region, although there are regions in the West and the South in which that has been approved. We would urge support in that effort.

There are more than 2,000 homes in Philadelphia right now where we know the children have been diagnosed with lead poisoning and they are waiting for the city to abate them—2,000.

Although lead is considered the most serious known widespread child health hazard, little research on solutions is being pursued. We at Philadelphia Citizens for Children and Youth convene a coalition to fight lead poisoning. We have several programs to educate the public to prevent it. We work extensively with the city's health department to try to come up with new ideas and new programs, but the problem is too big for any city, any county, or State.

Last year, a bill to tax lead batteries was introduced in Congress, the proceeds from which were to go to respond to this silent epidemic. We urge you to consider this approach to prevent the wasted lives caused by lead exposure.

Finally, some comments about the system. Children should be presumptively eligible for health care. States should not be penalized for providing care to children whose family income turned out later on to be slightly over the limit. States should, however, lose funds for not complying with Congressional mandates. Out-stationing is a prime example. We still do not have active out-stationing in Philadelphia or Pennsylvania. There is a small experiment at Temple, however.

We must stop creating barriers to care and then criticizing people for not jumping through the hoops. We can and must do better.

In North Philadelphia, in Manchua, and in Germantown, PCCY has been working to develop a child health outreach safety net. We have learned many things. One, it is extremely difficult for people to understand and therefore secure appropriate health care for their children. The systems build on each other and they have a lot of different eligibility requirements. Our families do move in and out of eligibility for Medicaid and for other programs fre-

quently, and our systems are not flexible enough most of the time to deal with these transitions.

Sometimes managed care presents a problem itself as a barrier because families move back and forth and no longer can get the care or can get to the care that they had originally signed up for. We have learned that the rules are often so complex that the government itself doesn't know its own. We have been training a lot of government workers on what those rules are.

We urge the Federal Government to shape a system which supports families, which strengthens the capacity of the systems to provide care to them, which encourages in a variety of strategies primary health care providers, particularly pediatricians, obstetricians, family practitioners, to practice and to practice in urban areas.

We urge the communities which do develop successful programs to maximally immunize their children, which provide more preventive care, which strengthen the efforts of families and communities to indeed do what we want them to do. We urge the Federal Government to reward them, to use some incentives for the extra efforts.

We at PCCY thank you for this opportunity and look forward to working with you on behalf of children. Thank you.

Senator WOFFORD. Thank you, and I will save my questions until all three on this panel have made their presentations.

Robert Sorrell is the Executive Director of the Urban League of Philadelphia, which has just recently done and published a most remarkable report. He is going to tell us some of the findings of it and make other comments, which I have had the chance to have a little advance notice of.

If you would start, I will be right back as soon as you get started.

Mr. SORRELL. OK. Well, thanks for the opportunity.

First, about the "State of Black Philadelphia Report", for 10 years the Urban League has put together a report which we call the "State of Black Philadelphia Report". It is an assessment of how well the African-American community is doing on a variety of issues. For the last 3 years, there has been a theme associated with the report. This year, the theme of the report was health. We thought that was timely. In fact, the subtitle is "Prescribing an Effective Health Care Agenda for our Community".

This is really put together as a volunteer effort. There are 12 authors who are professionals. They come from backgrounds in the medical profession, from insurance, from a variety of disciplines all contained in the health care arena.

And from that, we glean a perspective on what the health status, the conditions are within the African-American community, which is our primary concern. So the report is heavy on statistics and data which give us the background, but in addition to that, we ask each of the authors to give us the recommendations, what do we do about it, how can we make the quality of life or how can we make the system work better?

So we are very proud to have had that experience. In addition to having a press conference on this, we also had a health forum which was held at Community College—before I said Community College, I looked at Dr. Leacoris, it wasn't personal—we held that

at Community College. In addition to having our authors, of which Dr. Ross is one, and that is one paper I don't have to talk about, we had a couple hundred individuals who came to talk about their experience with the health care delivery system and we learned some things from that. There were just a number of recurring themes that we think are very, very important, some of which you have heard today.

I had hoped to present you with a copy of the report, Senator Wofford, but the weather and our printer did not cooperate. I can do something about the printer, but not the weather, but we will make sure that you get a copy of that.

Senator WOFFORD. And we look forward to putting excerpts, if not all of it, in the record of this hearing, with your permission.

Mr. SORRELL. Oh, that is exactly what it is for. We want to have as many people take a look at it as possible. It is a perspective, and I think we have a perspective on what the problems are and also what the solutions may be.

Overall, I would like to applaud your efforts too—and I won't read this testimony, I will give you a copy of it. Much of it you have heard, in terms of the horror stories and the statistics, and there are some real horror stories out there. I applaud your effort to reform the health system, but I think you have really taken on Goliath in your efforts to do so.

There are a number of stakeholders in this system. There is an awful lot of money involved, so I don't think reform is going to be easy. Our bottom line in the report is that we said we don't believe that the African-American community can wait until there is reform in the system, and in fact there are some things that can be done locally to have some impact upon the problem.

The problem is much like the problem of how you eat an elephant. Everybody knows that you eat an elephant one bite at a time, and we need more bites to be taken out of the elephant.

One of the things that Dr. Thad Mathis, who is from Temple University, pointed out is that health care is a commodity in this country. It is traded on the basis of the ability to pay. And as long as that is true, some people are going to have more access to health care than others, based upon their ability to pay, notwithstanding health care reform.

And so given that, there are some things that we believe that can happen within the African-American community that can have an impact upon some of the problems that are very, very dramatic, problems such as infant mortality, prenatal care, something that, of course, Dr. Ross talks about in his paper, problems of AIDS and alcoholism, even violence.

Many of these diseases or conditions having an impact upon behavior, we believe can have an impact upon the problems. You can have an impact upon AIDS if you can change behaviors, or we heard people say over and over in our health care forum a couple of things. One is people don't have the information, and you say, my God, with all of the talk that is going on, how could they not receive the information? There is a program that is implemented in the city by Independence Blue Cross, the Caring Program, which provides health care to infants, and we heard people say, we didn't know anything about that.

So there is a message. I think we have to develop more messengers and also maybe look at the message and how you get the information to people about the things that already exist and how do we get more people to utilize the things that are available? We heard that time and time again, and maybe you also have to take a look at the messengers in addition to the message.

The concept, and Dr. Thurmond Edmonds was one of the authors in this year's report, and he talked about instead of focusing on illness that maybe we have to change that around and start to talk to more people about wellness. Again, behavior modification can have some impact on some of the problems that we face.

Another recurring theme was that we have extensive networks within the African-American community that often are not involved, and they are not invited to be involved, in either the public policy formulation nor the planning nor the implementation. In many cases, we don't have to reinvent the wheel. We need more inclusion.

I know Senator Hardy Williams talked about inclusion. I think that is accurate. There are things that are there that are working and we need to build upon those and have more inclusion, because there are some people in neighborhoods who know. I mean, they know because they are there, they have been providing services, but they know the neighborhoods, and I think you have to utilize that in trying to have some impact.

I am very, very optimistic. I have seen Philadelphia do some things that have made a difference. The Philadelphia mortgage plan, for example, is a plan that has had an impact upon providing loans to people who normally would not be able to get loans in order to purchase housing. The Convention and Business Bureau MAC committee, which has had an impact upon tourism in the city of Philadelphia. I mean, Senator Williams talked about HMA. They have a citizens' advisory committee which has had some impact.

When we bring stakeholders to the table and have them have a sincere dialogue and challenge them to come up with approaches that have impact, we have been able to do so in the city of Philadelphia. The problem is getting players at the table, and since there are a lot of stakeholders in this industry, that is going to require, I think, a big effort but it is something that can be done.

We challenged ourselves within the Urban League that we are going to try and do that, try and bring stakeholders to the table to sit down and to decide and make a commitment to have an impact upon something, and there are a lot of somethings to have an impact on.

I mean, why can't we set a goal for ourselves in the city of Philadelphia while you are working on health care reform that we are going to do something about infant mortality? We are going to do something about making sure that the pregnant women get access to prenatal care, and the issue is how much can the hospitals do, how much can the doctors do, how much can the insurance companies do, but they can do something, and that was the whole premise behind the Philadelphia mortgage plan. The banks had to do something. Other stakeholders have to do something. They haven't eaten the whole elephant, but they have taken a bite out of it.

I think that we have to do that while we talk about reform. I am not sure what Hillary's bottom line is going to be and what you are going to be able to do in the short run, and so in the short run I think locally we have to have some initiatives that hold some promise and that will have an impact, and that will be putting the various stakeholders together at the table in order to try and have that impact.

We are optimistic because when this has occurred in Philadelphia, we have been able to have some impact. In fact, we would like to have your assistance in making sure that we get stakeholders to the table. There is an awful lot of money, as you have heard before, being made in this industry, and I think it is time to challenge those who are making a living and making a lot of money to put something back as we challenge corporations and universities and all other citizens to put something back.

I think that while it won't solve the problem, it can lead to some innovations. It can lead to an impact on some of the problems and it may develop some models so that when we do have reform, maybe some of these initiatives can hold a promise to have some additional impact.

Let me stop there and I will wait to answer any questions that you have. But I am very excited. I think the history in Philadelphia, the hardest part is getting past the initial stage of putting stakeholders at the table. Once you get them to the table, you can have some impact on these problems that we face in the health arena. Thank you.

[The prepared statement of Mr. Sorrell and the State of Black Philadelphia Report Executive Summary appear in the appendix, the full report is retained in the files of the committee.]

Senator WOFFORD. Thank you. I was impressed looking over your written testimony and even more so right now. We will put the full written testimony in the record too, and I will have some questions after we hear from Dr. Ross.

But let me say, I enthusiastically join you in the proposition that there is no need to wait for national reform to do what we can do. It is within our own reach. And I am tired, actually, of hearing about Rochester and Minneapolis and cities that have pulled together to take a lot of action. We have lots of things going in Philadelphia that we are hearing about this morning, and if we hear a little bit this morning, it is the tip of the iceberg of things underway in Philadelphia.

But it seems to me that not only should you not wait for national legislation, you will help promote that legislation and make it better, and then when it comes about make use of it fully if you find the ways and means of pulling the stakeholders and the powers that be from the community and private forces in the health care field in Philadelphia together for a Philadelphia plan that is a model for the Nation. That will be a major contribution, and I would love to work with you in seeing what we can do in that regard.

Dr. Ross is the Commissioner of Health for the City of Philadelphia and on other public forums has enlightened me and pointed the way and I look forward to hearing from you too today, Bob Ross.

Dr. Ross.

Dr. ROSS. Thank you very much, Senator. I appreciate the opportunity to be here as well as hearing some of the excellent testimony this morning. I don't know how much more I can add, but I will keep my remarks brief.

One of the things I do want to just mention, on the issue of immunization, you pose a very good question. I don't know why the immunization goal is 90 percent, quite frankly. It is a Federal goal that came out of some Federal bureaucrat's office, and I don't know why we don't have as a vision complete success in that regard.

I am quite certain that when Ronald Reagan was President or when Nixon was President and he talked about the goal of having a secure defense of this country, he never would have said, our goal is to have 90 percent success against attack from the Soviet Union. So I don't know why we settle for 90 percent as a goal.

But be that as it may, from here on in, let us say that we are shooting for 100 percent in the city of Philadelphia.

As the health care debate intensifies, Senator, I am troubled that the attention has been focused largely on two areas, cost control and access. These two areas of emphasis are critically important and necessary, but insufficient. The third piece, of course, is the role of prevention.

We are entering the final major turning point in public health in this century, and this turning point is known as health promotion, where health knowledge translates into real and definitive changes in behavior.

If you think about it, just sit back and look at the long history of man's quality of life on this planet. Man has inhabited this planet for maybe about 10,000 years or so and what is truly remarkable, when you think about it, is that in the last 90 years, which represents about one percent or so of the time that man has been on this planet, health care advances have permitted the average human being, at least in industrialized countries, to increase his or her lifespan by 50 percent, so that the typical United States citizen born in the year 1900 lived around 50 years and the typical United States citizen born today will live 75 years or more. That is an astonishing amount of progress in a very short period of time.

The first major turning point—I wouldn't call it a revolution, that might be too strong a term—occurred in the first couple of decades of this century, has greatly improved sanitation, plumbing, and hygiene. It accounted for a decrease in many communicable diseases like cholera.

The next major turning point, which I think would qualify as a revolution, took place from the mid-1940's to the early-1960's with the development of antibiotics and modern vaccines so that diseases like polio, diphtheria, and pertussis disappeared or nearly disappeared and diseases like pneumonia became treatable entities.

The top killers today, if you look at the top ten list of leading killers, are lifestyle diseases. Heart disease, stroke, cirrhosis, emphysema, suicide, homicide, AIDS, motor vehicle accidents, and even some cancers are all preventable through the adoption of healthy behavior.

The problem is a fundamental problem for United States health professionals, is that our track record in affecting behavioral changes has been spotty at best and generally poor. Conversely, our track record in technological advancement has been outstanding.

The classic example, of course, is cigarette smoking. In 1927, an article in the British Medical Journal "Lancet" linked tobacco use to lung cancer. The United States Surgeon General declared smoking bad for one's health in 1962. In 1992, we began to see bona fide changes in societal attitudes and behaviors about tobacco use, with its restaurants, airplanes, office buildings, or university settings. In other words, as far as tobacco use is concerned, it took the medical profession 65 years to get from point A to point B from the standpoint of changing behavior.

The reality is that aggressive price controls and a health insurance card for every American will not solve our health care crisis. Universal health care access will not alter addiction to tobacco, crack cocaine, or alcohol, nor will it convince a young woman that prenatal care or timely immunizations is critically important for her child.

Emphasis on the three P's, as I call them, constitute this important turning point in health care of the 20th century: prevention, primary care, and public health. All three of these important aspects in health care underscore and advance the importance of behavior and lifestyle in achieving good health. Unlike magnetic resonance imaging or coronary angioplasty, they are blue collar vocations in the United States health care business, they are relatively cheap, they are labor intensive, and they are not very sexy.

How do we get into the end zone on the field of prevention? Consider a few of these not so magic bullets. One is, and we are beginning to see some national attention on this front but we need to be a bit more aggressive here, and that is a moratorium on producing physician specialists. Let us produce more primary care practitioners by imposing a differential tuition and loan forgiveness structure on medical students.

Part B of that is to make prevention in medical education sexy or attractive, and if this fails, make it mandatory.

Third is to enlist Madison Avenue in the battle to promote healthy behavior. Public health is being mercilessly slaughtered by R.J. Reynolds, Coors, and other corporate entities in the marketing of unhealthy behavior. In 1992, the tobacco industry spent $4 billion to promote their products; public health spent $100 million to prevent it.

Next, and that is the categorical funding of programs in public health, which lead to narrow categorical approaches in the center. Hardy Williams touched on this in his comments. This may come somewhat as biting the hand that feeds us. We get money for lead poisoning, we get money for TB, we get money for immunizations, we get money for AIDS. However, what happens as a result of this categorical funding, and we have to spend that exactly as it comes from Washington, is that we end up treating diseases rather than families and we treat germs rather than people. There must be committed Federal leadership on comprehensive approaches rather than the disease-of-the-month approach that we now have.

Finally, a note about everyone's favorite buzzword and that is managed care. Managed care is neither a panacea nor a cure. Just like playing a musical instrument or preparing a meal, it can be done badly or it can be done well. Remember that there is a built-in incentive in managed care not to see the patient. The check comes in the mail every month even if the patient doesn't, so managed care providers must be judged on the basis of immunization rates, lead poisoning screenings, and adequacy of prenatal care visits. This is of particular importance in Medicaid managed care, which will sweep Philadelphia and the Nation to follow.

Emphasizing prevention, finally, in the United States health care system is counterintuitive to the industry. Unfortunately, effective communication and health empowerment of the individual are not billable services. The challenge is how do we make these items important and very real, and I think that I will again echo Senator Williams' remarks. I think we do have a contingent of very committed, risk-taking, smart folks in the city of Philadelphia.

I know sitting here at Temple, and I have had a number of discussions with Vice President Leon Malamud at Temple, and we are talking about how do we create a partnership in terms of primary care and public health between the health department and Temple University, and I am not sure what that partnership is going to look like but we are going to have one. We are going to work together in terms of working with our health centers to make sure that primary care and prevention is improved and enhanced with our health centers.

So with that, I am open to any questions that you may have, and thank you for this opportunity to testify.

Senator WOFFORD. Thanks to all three of you.

I just want to test out one idea that our Governor put forth with a little controversy about a week ago. To deal with the problem of getting people into preventive and primary care and serving underserved areas, rural and inner city, he suggested that along with strong measures to control costs across the whole board, very strong measures, there should be strong measures to get young doctors at the beginning of their career in serving underserved areas, and he said instead of just having incentives, he would condition aid to going through school to a couple of years or more in serving in underserved areas.

Have you had experience with, what is it, the medical service corps——

Dr. ROSS. Yes, the National Service Corps?

Senator WOFFORD. [Continuing]. The national health corps?

Dr. ROSS. In fact——

Senator WOFFORD. And what would you do to expand it, if anything?

Dr. ROSS. In fact, let me cite two examples. One is myself and one is a friend of mine who is now the State health commissioner in Texas.

In training at the Children's Hospital of Philadelphia, which is a tertiary care-oriented institution, does also provide good community pediatrics and ambulatory pediatrics, but in the academic medical training setting, there is no question that what is sexy about medical training are the tertiary care and subspecialty prac-

tices, intensive care medicine, emergency medicine, critical care medicine, cardiothorasic surgery. There is a lot of high tech, there are a lot of buttons, a lot of bright lights, a lot more money.

It has been difficult, I think, given that setting, to turn young physicians on or physicians in training onto how exciting primary care and preventive medicine can be.

The turning point for me came when I had to, I was obligated to, provide 3 years paying back the Federal Government on a National Health Service Corps obligation in Camden, and that was a very exciting aspect of care for me. But by the time I finished my medical training at the Children's Hospital of Philadelphia, I was pretty certain that I was going to go into either intensive care medicine or emergency room medicine. That is what just seemed attractive to me.

And ditto for a friend of mine, David Smith, who hated primary care medicine while he was at ambulatory pediatrics while he was at the Children's Hospital of Philadelphia, knew as soon as he finished his National Service Corps obligation he was going to go back to the academic setting and go into tertiary care, and he has since then gone into public health and is now a terrific State health commissioner in Texas, very committed to community-based primary care.

So I don't know whether you do it by the carrot or by the stick, but I think that every young physician in training has got to be exposed to what it is like to work in a community, to work with the Greater Philadelphia Health Action, to work with the district health center, to see what it is like to work with the neighborhood organization to advance a lead poisoning project or an immunization project or a prenatal care project, and it can be very gratifying. It is challenging, and it goes beyond the rather sanitized technological advancements that we used to.

Senator WOFFORD. You all three have, I think, conveyed to us how vital it is that part of the solution come from people upward rather than from programs downward, from the sense of individual responsibility that Robert Sorrell stressed, and Shelly Yanoff was pointing out that it isn't all going to come from people going out from some bureaucracy to do immunization. Parents and families need to come in to get the immunization.

Do any one of you want to add anything more on the aspect of the individual and individual responsibility for health that could transform a great part of the problem, if we know how to do the education of our parents and of our citizens that would produce that kind of individual responsibility?

Who would like to comment on that?

Ms. YANOFF. I think, Senator Wofford, that the only thing I would like to say is to underscore that the system has to be hospitable to the families and it has to help them. It has to be there when they need it.

It seems to me that particularly with poor people and poor families is that it is more interesting to talk about the sticks than the carrots. Why shouldn't we have immunization sites regularly in schools? I mean, when are we going to have the network that has been promised, it seems, for a very long time so that there can be a system if you get your immunization at one point, your first im-

munization, or before you leave the hospital as a newborn, there should be a call in, there should be a way of notifying people, an outreach worker if it doesn't work to go and send the card and if you haven't made contact.

I just think the system has to be there in order for there to be a community and system partnership, and I think part of that is capacity and part of that is commitment.

Mr. SORRELL. I would just like to reemphasize that without teaching individuals, individual responsibility, you leave big holes, I think, in the system ultimately. Ultimately, your health becomes your responsibility and there is a system there to service, to assist, to support, but if we can prevent more people from going into the system or spending more time in the system, it seems to me that that has some impact upon cost but also improves the quality of life for the individuals. The issue is how do you get that. That is a long-term project, understandably, but I think it is a long-term project that we need to venture into.

I think Dr. Ross' example about what Madison Avenue spends on the other side, I mean, there are some forces out there that have to be combatted and maybe particularly focused at young people and maybe some older people also. But without a counter, we have young people who believe that, if they are like my 14-year-old, that they are going to live forever and that, of course, Genesis began with them. We have to turn some of that around.

I would like to focus as a first effort on maybe one or two things. Let us see if we can take a bite out of one or two things before we move to trying to cover the battlefield, and I don't know whether or not that is prenatal care, maybe that is a focus. But I think if we could do that, there is nothing like success and I think you could start to build upon that.

It is just getting, I think, the players at the table to say, what can we agree on as a good first effort and utilize the resources at our disposal, whether or not they are insurance companies, whether or not they are community-based clinics or community-based health care delivery systems. Just use what is at our disposal and see if we can't, because a lot of what we are hearing are diseases where the behavior can have some impact on, so why not?

Senator WOFFORD. Anything further, Robert?

Dr. ROSS. No, I just think we should take up Mr. Sorrell's challenge. I think right now we are at an opportune moment in that we have some folks in the White House that are committed to child health and to immunizations. We know that there has been a challenge issued by the President on the issue of national service and higher education——

Senator WOFFORD. And that it be focused on children, immunization, children's health——

Dr. ROSS. Exactly, and the challenge for us right now is—I mean, I would like to assume, although I hope I am wrong, I would like to assume that if not one extra dollar came to the city of Philadelphia for health care from Washington than what we have now, how do we get to 100 percent immunizations? And what is the role of the university community, not just Temple University School of Medicine or University of Pennsylvania School of Medicine, what is the role of academic institutions as soldiers in making sure that

every kid is immunized? How does that work? How could we make that work? What could we do in Philadelphia about that? And once you get that victory in your pocket, then you go to the next one.

So that is where hopefully the Philadelphia with a wealth of academic institutions and higher education institutions and medical schools and hospitals, how can we work the city health department to make sure that every kid is immunized, and I think that is one of the things we are trying to do now.

Senator WOFFORD. One of the things that gives me hope is that not only is a sense of crisis as to the overall costs and overall inadequacy of preventive health care systems in the field of health in America spreading at the national level, and the ground for action coming at the national level, but all around this country and all around this commonwealth, as you are showing around this city, people are rising up to deal with the issue of health.

I can't tell you how encouraging it is to see cities from Erie to Philadelphia begin to say, we can't wait, and as cities do that, as communities do that. As people come together, it will throw light on what we need in the national level in the public health field in preventive medicine.

I think a role I want to help play in the next months, and this, as you say, is not going to be over, this issue, until we get a good American system of health care for everybody that is affordable and focused on preventive and primary care, we can't rest content and I am not going to rest content. But I think combining what is coming up from communities and neighborhoods and local institutions and the response in the national level gives us the chance to really change our system of health care for the better.

Temple University's television coverage of this, I appreciate greatly, and it has about run out in terms of their first tape.

We will be here to talk to some of the people that would like to pursue these questions further who have been patiently listening.

This is just the first of a number of hearings that I will be taking around Pennsylvania and the first of many stops in Philadelphia, and I look forward to working with the witnesses we have had today and with others who could have given us testimony today to turn the right of affordable health care with a major emphasis on preventive and primary care into a reality in this city, in this commonwealth, and in this country.

Thank you.

[The appendix follows:]

PREPARED STATEMENT OF DR. FREDERIC KAUFFMAN, DIRECTOR, EMERGENCY MEDICAL SERVICES, TEMPLE UNIVERSITY HOSPITAL

INTRODUCTION

Good morning Senator Wofford, distinguished guests, and members of the Temple University family. My name is Dr. Frederic Kauffman. I am the Director of Emergency Medical Service at the Temple University Hospital. I am Board Certified in Emergency Medicine and Internal Medicine and hold the academic rank of Associate Professor of Medicine at the Temple University Medical School. My home is in Rosemont, Pennsylvania where I reside with my wife and three children.

TEMPLE UNIVERSITY HOSPITAL - A PROFILE

Temple University Hospital is a 504 bed Academic Medical Center located in North Central Philadelphia. Annually we provide care to approximately 17,000 inpatients with 36 percent of those admissions entering through our Emergency Room, many the result of violent trauma. We deliver 2,400 infants each year, approximately 60 percent of whom are born to high risk mothers and 15 percent have documented cocaine breakdown products in their urine. Our Medicare case mix index is 1.84 this indicating an acutely ill population. In the Commonwealth of Pennsylvania there are only 8 other institutions with a case mix index greater than Temple. We are currently the fourth busiest heart transplant center in the Country.

Temple was officially recognized by the Federal District Court of Eastern Pennsylvania as a low cost academic medical

center. We provide more indigent and trauma care than any other single institution in the Commonwealth of Pennsylvania. Unlike most institutions, 59 percent of Temple's trauma cases are related to attempted homicides. We receive no direct financial funding from the State or County in support of our public mission. During the fiscal year which ended June 30, 1992 we provided approximately $12,000,000 of free and underreimbursed care and we are designated as a super disproportionate share hospital under the Medicare Program. Temple University Hospital is truly a safety net institution providing critical access to healthcare for an often underserved population.

A TYPICAL SHIFT IN TEMPLE UNIVERSITY HOSPITAL'S EMERGENCY DEPARTMENT

Senator Wofford, my principal purpose today is to address the impact on Temple's Emergency Room from a lack of sufficient primary and preventative care in the North Philadelphia area.

Urban Emergency Medicine represents a tremendous medical challenge for all levels of healthcare staff. However, such a professional challenge is not without periods of extreme emotional and physical stress. What makes this area of medical delivery system so professionally stressful is the unpredictability of the demands for our services. A typical Friday night in the Temple University Hospital Emergency Room will bring 6 or 7 trauma cases most the result of attempted homicides and other violent crimes.

Drug deals gone bad commonly result in victims arriving in rapid succession, and placing immediate stress on not only emergency room staff, but throughout the Hospital. Neurosurgeons may be needed immediately for a victim of a gunshot wound to the head. The baseball bat victim often needs the not only the Trauma Team (for injuries such as ruptured spleens and lacerated livers), but also Orthopedic Surgery (for broken arms and legs) and Neurosurgery (for intracranial hemorrhage).

While such lifesaving care is being delivered, throngs of less emergent patients gather in the emergency area. Once the immediate emergencies have been stabilized, the staff can begin to attend to the patients in the waiting room.

The patient with a seizure disorder is evaluated, knowing nothing about his/her past medical workup, taking unknown medications, abusing alcohol, and unaware of the last time he/she visited a doctor. The emergency physician is left with no meaningful information; subsequent evaluation is costly; clinical workups are unknowingly duplicated.

Poor access to quality primary care, coupled with the social ills of urban society, represent a potentially deadly combination. Totally avoidable problems may rear their head upon presentation to the emergency department. The young pregnant woman who abuses cocaine arrives 8 months pregnant with no prenatal care, in active labor and bleeding. She suffers from placental abruption, a complication of cocaine abuse, and requires emergent management from obstetrical staff if she and her premature baby are to survive

Recently, the following true life scenario occurred during an evening shift at Temple University Hospital. The Emergency Department was filled to capacity; all acute care beds were in use with the exception of the bed reserved for victims of serious trauma. The waiting room for non critical patient care was also full. Without warning a victim of a drug deal gone bad arrived in critical condition with a gunshot wound to the leg; Temple's Level I Trauma System was activated. Within minutes a second patient was dropped off by his "friend"; the patient had suffered a near respiratory arrest due to a heroin overdose. Later, a third victim of an intentional self-inflicted overdose arrived, lethargic and in need of emergency airway management. Moments later a fourth victim of a serious motor vehicle accident was brought in by fire rescue; once again the Trauma System was activated. All four of these patients required emergent and highly sophisticated medical management. All four patients arrived within the span of fifteen minutes Stressful?-yes; unusual? - no.

WHEN PRIMARY PREVENTATIVE HEALTH CARE FAILS: IMPACT ON AN URBAN EMERGENCY DEPARTMENT

Not all care provided by urban emergency departments is as graphic and emotionally draining as that noted above. Despite the results of inner-city violence, social ills and substance abuse some patients seek nonurgent care through emergency department systems. In essence, emergency departments in the inner-city run two types of practices:

a) acute, emergent care often necessitated by the violent and

poverty stricken inner-city social fabric; and b) primary medical care in the community. The implications of this type of nonurgent primary medical care delivery in a busy, overcrowded emergency department are predictable:

- noncritical patients wait inordinantly long hours before receiving medical care
- patients become frustrated and angry
- many ultimately leave before evaluation, the wait and suffering having become too great
- physicians become anxious and worried about the patients building up in the waiting rooms; are some of them sicker than initially appreciated at the time of triage?

It must also be emphasized that urgent and emergent care many times is necessitated by the failings of community primary care preventative measures. Several classic examples exist. Several years ago a major measles epidemic broke out in Philadelphia. Children who had not received routine immunizations contracted the disease; some of them died. Basic preventative care of the well patient would have prevented the need for future emergent care. Likewise, a common emergency department patient is the individual with an acute flair of asthma having been precipitated by noncompliance with appropriate medical regimens. The sense of shortness of breath is unpleasant for anyone; primary patient education would serve to inform the patient that medical compliance is necessary even when the patient feels well if emergency visits

for wheezing and shortness of breath are to be avoided.

In addition, an unfortunate burden of managed care rests by default on the emergency department, the very site which willingly and by law evaluates every patient which comes through the doors. The patient comes to the emergency department for a non-emergent problem because in many cases timely access to primary care is not delivered; the primary care physician "ok's" the visit; ultimately the patient is evaluated and discharged by the emergency department staff. Lastly, in the retrospective evaluation of the visit by utilization staff of the insurer, payment is denied to the emergency department, with the claim that the visit was not an emergency. The site where service can ultimately be obtained when all else fails ends up receiving the penalty for providing the care not available through primary care avenues. One additional and unfortunate scenario also exists; all too often the primary care provider is unable or unwilling to provide meaningful background medical information to the emergency department medical staff that otherwise would allow for a more efficient and cost effective evaluation to take place.

So what is needed to address the care of the nonurgent patient? The answer goes well beyond simply increasing the number of primary care physicians in the urban setting. Timely access to quality care is mandatory. Adequate numbers of physicians will not guarantee this, nor will ready access in and of itself. Access without quality is a charade, and alleviates no

pressure from the emergency department. Patients seek out quality care; when denied, they will ultimately return to the one location where they will be granted quality care regardless of complaint. In order for inner-city emergency departments to be relieved of this burden readily accessible primary care of high medical standards must be available within the community.

TEMPLE'S RESPONSE TO THESE ISSUES

Temple University Hospital and Temple University School of Medicine have attempted to take a proactive approach to the issues of primary and preventative urban health care. Several programs have been developed in an attempt to ease the burden on emergency services, to provide preventative care so as to prevent illness before it starts, and to provide quality primary medical care staff to the community. These programs include the following:

1. Walk In Care Center - This nonurgent care center is designed as a fast-track system to provide quality medical care to those patients who present to the emergency department but who do not need emergent care. Recruitment and retention of personnel for this Center has been difficult. Many medical professionals simply do not want to work in a primary care setting in such close proximity to the results of urban violence.
2. TIPPS Program - With the help of the William Penn Foundation this outreach program to women with high risk pregnancies seeks to identify potential complications of pregnancy early on, thereby

establishing an opportunity to lower infant morbidity and mortality. Ongoing in-home and in-office evaluation optimizes pre-natal care and helps prevent the disasters which all too often occur when a young mother shows up for the first time to the medical system, in active labor and about to deliver. Preliminary results have indicated that the program is having a positive impact through increasing birth weights.

3. Primary Care Network Development - Temple University Hospital is a founding member of the Health Partners Health Maintenance Organization whose mission is to bring a coordinated managed care delivery network to the Medical Assistance population. Health Partners has been in existence since 1985 and currently serves over 50,000 individuals. Temple has recruited the largest single share of those subscribers numbering 9,200 as of February, 1993. Temple achieved this enrollment through forming partnerships with those area physicians that were able to successfully meet our credentialing requirements. To date we have 23 primary care sites and are looking to further expand this access through forming similar partnerships with the City of Philadelphia's Health Districts which are in Temple's service area. Equally important, Health Partners does outreach in two areas (1) substance addiction education for children 3 through 8 and

(2) education on the importance of pre and postnatal care.

4. Institute of Primary Care - Temple University School of Medicine recognizes the need to train highly skilled physicians dedicated to the field of Primary Care Medicine. Temple's Institute of Primary Care introduces all medical students to the challenges and rewards of primary care during the student's first year of medical school. Relationships are established with dedicated Primary Care Physicians who serve not only to teach basic clinical skills to the student, but who also serve as role models for the student searching for his/her niche in the field of medicine.

It must be stated, however, that quality medical school education will only go so far in influencing one's specialty. If quality Primary Care Physicians are to be recruited and developed in meaningful numbers, they will have to be well paid, and educational loans dealt with so that financial viability will be feasible within their chosen career pathway. It will do no good to turn on students to the challenge of Primary Care if personal financial viability is not possible.

Temple recognizes the merit of the above programs, and strives to serve the local urban community via solid clinical programs based on clinical excellence. One final fact must never be forgotten in any program development, that is that the

program must be tailored very specifically to the needs and social structure of its patients. A recently performed study in our Emergency Department discovered that the average reading level of our patients is fifth grade. In addition, despite access to written discharge instructions, coupled with verbal instructions, nearly 25% of patients immediately upon discharge from the Emergency Department had no or minimal understanding of discharge instructions. Primary care clinical programs will fail if the other deteriorating influences within the urban environment are not addressed.

Finally, Senator, please do not forget the other side of my dilemma, the true emergency room which sees the violence of today's inner-city. No amount of primary care will eliminate this need. I am deeply concerned that the current proposals to reduce medical education funding by as much as $5,000,000 a year at Temple University Hospital, a super disproportionate share institution, will severely impair our ability to deliver these needed services.

REP. DAVID P. RICHARDSON, JR., CHAIRMAN

HOUSE HEALTH AND WELFARE COMMITTEE

TESTIMONY BEFORE THE SENATE

LABOR AND HUMAN RESOURCES COMMITTEE

"SOLVING THE URBAN HEALTH CARE CRISIS:

THE ROLE OF PREVENTION"

MARCH 15, 1993

Good morning, Chairman Wofford, Members of the Committee, and my fellow panel members. The State Health Data Center of the Pennsylvania Department of Health recently published a series of Health Profiles for each county and one for the Commonwealth. The Health Profile of Philadelphia County indicates that the leading cause of death for age groups 5-44 is homicide, followed closely by injury. Although research shows that interpersonal violence has a disproportionate impact on minorities, this is not a phenomenon associated solely with Philadelphia or other major cities. It is an American problem affecting all communities, in all parts of society.

In his Health Journal article, Vol. 9 No. 4, titled The Roots of Rage: Buried Feelings-in People or Cities-Can Erupt in Violence, Dr. Keith Russell Ablow of the New England Medical Center in Boston uses the Freudian psychological theory to understand urban violence. He first explains that the job of the ego is to find ways for a person to express unacceptable feelings without violating social mores and the concept that communities have an emotional life, just as an individual does. He then states that the process of building self-esteem in a self-destructive patient requires a trusting, non-judgmental therapist and postulates that the process in a community while more complicated also requires open and honest discussions with authority figures who ask

questions and listen more than they talk. In other words, we as elected officials must go out into the community and listen to everyday people. How many members of the community will testify here today? Are two, three or four enough for this Senate Committee to understand urban health problems?

The Assistant Dean at the Harvard School of Public Health, Deborah Prothrow-Stith, states in her book, "Deadly Consequences: How Violence is Destroying Our Teenage Population", that violence, like AIDS or heart disease, has identifiable high-risk groups and prevention strategies must be tailored toward them. She concludes that afternoon, summer and weekend school-based educational programs and government financed recreation programs are necessary, so that children of working parents have a place to safely learn and play after school.

The City of Philadelphia Recreation Department has had to reduce it's overall budget by 3%, decreasing hours of operation and eliminating resources. The Department currently oversees 196 recreation centers and playgrounds, and 56 parks. During a time when these services are desperately needed by our young people, fiscal resources to urban areas are dwindling faster than likewise large reductions so state budgets because Congress thinks reducing the deficit is more important than health care and other social programs that save lives. Washington has to get its priorities straight!

Over the last decade, the Reagan administration tried consciousness-lowering along with an undisguised political move to wipe-out anti-poverty programs, better known as trickle-down economics. That Republican administration

threw up a wall of negative rhetoric, one of the most famous lines being, and I quote, "the failed War on Poverty." Now a Congress, afraid of change, wants to continue the Reagan/Bush war on poor people. If Congress doesn't accept change, the people are going to change Congress.

Nationally, violence has reached epidemic levels. Studies by the Centers for Disease Control in Atlanta indicate that the majority of the homicides that occurred in 1988 were intra-racial, that is African-Americans killed African-Americans and whites killed whites. The majority of homicides also occur between family members or acquaintances. One third of all female victims in 1990 were killed by their husbands or boyfriends (only 4 percent of male victims were killed by their wives or girlfriends).

Violence is a deadly disease, the number one killer of young African-American men. Homicide and intentional injuries are at the heart of "the Urban Health Care Crisis".

Primary prevention is defined as prevention of an illness or disease before any symptoms manifest themselves. After the Los Angeles riots, the Director of Public Health Programs for the Los Angeles County Department of Health Services said of efforts to prevent urban violence, "We're in very much uncharted territory here." But, recent studies, including one by the Injury Prevention Center at Johns Hopkins University School of Public Health indicate that violent injuries are not randomly occurring events. They are actions with patterns involving people who are more at risk, living in areas where violence is more likely to occur.

Despite the best efforts of the old Washington bureaucracy, programs that reduce the risk that an adolescent will commit a violent act, leave school, bear a low-birth weight baby while still in her teens, and of other damaging behaviors that reach into the next generation, are alive and well in Philadelphia's Communities. Although all of the following programs have demonstrated that they work, none has sufficient financing to expand beyond small community based efforts or funding sources which guarantee their existence from year to year.

I am sure Commissioner Ross will go into detail about the demonstration project to reduce infant mortality rates in which 47 community organizations in West and Southwest Philadelphia provide a wide range of innovative community and clinical services. Healthy Start is relevant to my theme of violence prevention in that good parenting and life skills programs are key in stopping the chain of violence. Dr. Keith Ablow, in another Journal article, states that violent patients were, almost invariably, severely abused physically and emotionally as children by their parents.

I wish that Deputy Commissioner Chu Chu Saunders were here today to speak at length about Operation Peace in Philadelphia (OPP), a seven year initiative with the goal of eradicating youth violence. It is a community wide effort involving eleven action teams. The teams are charged with the identification, creation and implementation of immediate and long term violence prevention strategies.

The House of Imoja, a West Philadelphia community based organization with a 25 year history of responding successfully to crises in Philadelphia neighborhoods, has in a fight to preserve our community initiated a new campaign to put an end to violent crime. The House of Umoja

has a great deal of experience in this area, having orchestrated the "No Gang War in '74" anti-gang violence campaign.

R.O.O.T.S., a program funded by the Salvation Army, was formed to help the families of incarcerated Philadelphians deal in a positive manner with their fears, anger and frustrations and, thereby, break the chain of non-productive violent behaviors through a positive dialogue with corrections counsellors, attorneys, bail fund representatives, probation and parole agents and others who might be able to assist prisoners' families.

The Philadelphia Anti-Drug/Anti-Violence Network's 5 area teams provide 24-hour, immediate response to violent incidents. PAAN's focus is on breaking the cycle of violence through intervention and mediation. They also offer technical assistance in developing activities for at risk youth, prevention education and drug and alcohol treatment referrals.

These are good programs. They must be sufficiently funded, expanded city and statewide. They prove that, together, we can work to provide reasonable alternatives to violence, and give people in our communities hope for the future.

In closing, I would like to thank you for this opportunity to share my views, experience and the expertise that has come to me as Chairman of the Pennsylvania House Health and Welfare Committee and as past Chairman of the House Urban Affairs Committee.

WORKSHOP: **HEALTH**

Facilitators: Robert Ross/Kim Mills

Summary of the morning session included the following issues for discussion for Coalition Building:

- Quality Health Care for African-Americans
  Major Issues:
  - Cancer
  - Heart Disease
  - Strokes
  - AIDS
  - Homicide
  - Lung Disease
  - Liver Disease
  - Kidney/Blood Disease
  - Sickle Cell Anemia
  - Accidents
  - Diabetes
  - Mental Illness
  - Poverty

- Problems in Health Care:
  - Racism
  - Access of care
  - Lack of Resources
  - Specialization
  - Centralization
  - Attitudes
  - No accountability/not held responsible as individuals
    CBO's Health issues among the incarcerated (county/state/federal)
  - Nutrition issues regarding junk food" for children within the Public School System

RECOMMENDATIONS:

- Economic improvement/Outreach
  Identify/support CBO's that act in our interest, such as:
  - Barber Shops
  - Beauty Salons
  - Churches
  - Social events
  - Musical (rap)
  - Videos
  - Literature (kits)
  - Ex: H.P.C.
  - Black Doctors
  - Hill/Burton Act
  - Mutual respect
  - Caring, Loving

- One-stop shopping
- Empowerment
- Health Start Model
- Health Center Community Advisory Boards
- Government Board

Organize/develop a plan/strategy, develop partnerships, share in decision-making, appropriate representation, education/awareness, satellites-comprehensive decentralized care, one-on-one outreach training for youth and community people, city-wide Health Coalition advocate, lobby-activism.

I. COALITION BUILDING

A. Who/What Organizations Need to be Involved
- Citywide Health Coalition
- African-American controlled health organizations/individuals
- MAC
- Plan
- African-American Delegates/Participants
- AIDS Leadership Forum
- Charles Drew MH/MR Center
- Sickle Cell Council
- WP Coalition
- CBNP

B. What New Programs Need To Be Established
- Develop/establish community-based health education/awareness programs and efforts]

C. What Research Is Needed
- Our own research institution
- Urban League
- Use existing programs

III. RESOURCES

A. What Resources Are Needed
- Money - private and public, and by any other means possible
- Supporting of ourselves (African-American money)
- Resource Directory
- Organizational Development
- Technical Assistance
- Marketing Plan (to attract others to Coalition and to highlight issues)
- Sweat Equity
- Total Community Support
- Office Space
- Meeting Space

B. What Resources Are Available
- Volunteers
- Governmental funding
- Managed Care Providers:
  - Mercy Health Care
  - Health Care Alternatives
  - Health Partners

Health Care Testimony
Robert W. Sorrell
Senate Committee on Labor and Human Resources
Monday, March 15, 1993

Temple University

Good morning, my name is Robert Sorrell and I am President of the Philadelphia Urban League.

I am pleased to be invited here today to comment on an issue that is desperately in need of attention both on the national and local level – the health care crisis.

My perspective on this issue focuses on health care and its effects on Philadelphia's largest minority population. Perhaps nowhere in this nation is the crisis in health care more apparent than in Philadelphia. Few American cities can boast the wealth of health resources the city offers: hospitals, professional schools, community health centers and research programs.Yet, despite these resources, African-American Philadelphians are suffering and dying due to lack of access to affordable and quality health care services.

In addition, for various reasons, some having to do with long patterns of discrimination and exclusion, the national health care crisis is having an even more chilling effect on African-Americans than on the general population.

The Urban League's tenth report on the "State of Black Philadelphia" addressed the issue of health care as it pertains to the black community. Contained within the report is the culmination of months of work by some of Philadelphia's most respected experts on health care and on the health status of African-American people.

The "State of Black Philadelphia Report" reveals some alarming statistics – just a few of which I would like to present to you:

- In their essay, Rackell Arum and Constance Williams pointed out that in 1990 the infant mortality rate for non-white Philadelphians was 22.1 per 1,000 live births, as compared to 7.9 per 1,000 births in the white community. The authors added that, in the same year, more non-white Philadelphians lost their lives before their first birthday than did non-whites between the ages of one and twenty-four.

- According to A.J. Henly, the number of non-white women in Philadelphia who received no prenatal care before the last three months of pregnancy has been increasing steadily since the late 1970's. In 1977, 7.8 percent of non-white women received inadequate prenatal care. By 1989, the percentage had increased to 23.2%.

- Addressing the issue of access to health care, Dr. Ross and Pamela Keels, noted that although Philadelphia claims the highest concentration of health care providers per capita in the country, the number of physicians available to service poor and minority communities is critically low. As an example, they report, Philadelphia has no public hospital. In addition, less than 2 percent of the City's 6,950 physicians have their main practice sites in Southwest Philadelphia, where 5.1 percent of the City's populations resides; and North Philadelphia has 8.5 percent of physician practice sites to service its 16.8 percent of the City's population.

- In summarizing key findings of 1992's Pennsylvania Conference on African-American and Minority Health Issues, State Representative Richardson – whose testimony you heard earlier – focused on the Commonwealth's low percentage of

African-American health care professionals and medical students. Rep. Richardson noted that, in 1988, minority students represented just 5.8 percent of the 1,017 medical students graduating from Pennsylvania medical schools.

- In his article regarding the social politics of health care.

Temple Professor Thaddeus Mathis details what he calls the state of "healthlessness" in which Philadelphia's African-Americans exist. Mathis defines this "healthlessness" as a set of social conditions that are hazardous to the health of African-Americans. Mathis further points out that the American health care system, in general, is shaped and maintained by an extensive system of cultural and class factors, and that health care in the United States is a commodity to be bought and sold and reflects this in its cost structure, availability and degree of specialization.

As a result, cites Mathis, as recently as 1983 only forty-four percent of African-Americans who received health care were treated by a private physician in his/her office; 26.5 percent in a hospital emergency room, and 9.7 percent in outpatient clinics. The corresponding rates for whites were fifty-seven, thirteen and sixteen percent, respectively.

These are some of the problems, now what about solutions?

To address these and other findings outlined in the "State Report", the Philadelphia Urban League has called for the formation of Health Care Industry/Community Leader Task Force. The purpose of this task force will be to develop community outreach and education programs intended to promote wellness and healthy lifestyles in the African-American community.

The formation of this task force is necessary because as the national dialogue about health care rages on, African-Americans continue to suffer disproportionately, and to die disproportionately, from sickness and disease and from the lack of preventive services.

Accordingly, the Urban League is in the process of scheduling a series of strategy meetings in the coming weeks with local health care industry and community leaders to beginning putting together this task force. This task force will have as its primary goals the following:

1. To develop a strategic plan aimed at conveying the message to the local African-American community that self-reliance and a proactive attitude toward preventive care are critically important elements to establishing healthier lifestyles.

2. To serve as a vehicle through which health care institutions such as hospitals, clinics, health insurance providers and others can develop, organize and implement community outreach and education programs to assist in establishing a commitment to healthy African-American lifestyles.

3. To facilitate information sharing and brainstorming among a cross-section of key community health care "players" with the purpose of finding new and more efficient methods to address the health care crisis at the grassroots level.

I am optimistic about the potential of this task force. However, let me state clearly that we will need help from leaders such as yourselves -- our lawmakers. As you gather information here and in future hearings across Pennsylvania, I urge you to continue to work in earnest in the Washington to correct the problems eroding our nation's health care system. In a country that spends 14.4 percent of its gross domestic product on health care (Nine-hundred-billion dollars this year alone -- up from 250 billion in 1980), we must find a way to use these dollars more efficiently to improve access, affordability and quality.

In conclusion, the Philadelphia Urban League strongly recommends that the Committee seriously consider the inclusion, in your final health care reform plan, of our community-based task force approach to addressing the African-American health care crisis. The impact of this proposed program in Philadelphia and across the Commonwealth, I believe, will be significant.

WELLNESS IN A DESPERATE AFRICAN-AMERICAN COMMUNITY
Executive Summary

Therman Evans, M.D.

Wellness is an empowering notion. It is an enabling notion. The concept of wellness challenges individuals and institutions to assume appropriate responsibility for maximizing the potential of life situations. High rates of disease, disability and death in Blacks are largely the result of decades of active, overt, oppressively discriminatory behavior by whites, have contributed to the poor health status of Blacks.

In a real sense then, poor health status results largely from the stress of being Black in America. The victims, in seeking relief from this "stress" have adopted lifestyle behaviors that provide immediate gratification but, in the long run, contribute to worsening the situation from which relief is being sought. Through negative, nonproductive lifestyle habits, Black people are co-partners in their own self-destruction.

For example, smoking tobacco is the greatest risk factor for cancer in Black people. It is responsible for nearly 40 percent of all cancer deaths among Black men and 20 percent of cancer deaths among Black women. Another example is drinking alcohol to excess. Alcohol consumption is considered to be the primary cause of cancer of the esophagus. Black men, aged 35 to 44 years, experience cancer of the esophagus at a rate that is ten times that of whites. Cirrhosis of the liver, directly related to the consumption of alcohol, is responsible for a rate of death among Blacks that is virtually twice that of whites. AIDS is essentially a consequence of behavior (use of unsterilized needles and involvement in unsafe sex) and, again Blacks are carrying a relatively heavier weight.

The health hazard of being Black in America, unlike the state of being Black, is not irreversible. I believe the negative Black health picture would begin to reverse itself if certain other things were reversed. These include poverty, inadequate educational opportunity and advancement, inadequate nutrition and housing, unemployment, and yes, racism and discrimination. Some may ask, "What can those in these circumstances do? How can they change these circumstances? Are they to blame for their health status? Why should the victims have the responsibility for their health?" Is this blaming the victim? I do not think so. Looking back over Black life in America, specific conditions have changed a lot, relative conditions have changed very little. All change, whether positive or negative, is stressful for people. The degree that self-destructive behaviors continue in Black communities is the degree to which future health reports will continue to indicate higher rates of disease, disability, and death in Blacks.

Self-reliance is a prescription that, if subscribed to, will result in improved health for African-Americans. Self-reliance is a prescription for improved health for African-

IS NATIONAL HEALTH INSURANCE A CURE FOR BLACK AMERICA?

Executive Summary

A. J. Henley, M.A.

National health insurance is important to African-Americans because it would provide access to health care services to persons whose ability to pay for service is limited. African-Americans are three times more likely than whites to live in poverty and therefore are more likely than whites to lack adequate health care insurance. Instituting national health insurance will not solve the health crisis facing the African-American community. Almost thirty years ago, this country broadened access to health services as a way to improve the health and lives of poor and minority citizens. Concern about limited access to health services for low income, elderly, disabled and chronically-ill persons resulted in the creation of Medicaid and Medicare. These programs pay health care costs for millions of Americans using public monies. Although there have been improvements in access, major problems remain.

Even with increased access to health services, the overall health of African-Americans remains far worse than that of whites. There are now areas in which the health status of African-Americans is actually declining. These declines are occurring primarily among persons who are insured through Medicaid. It is disturbing that many current proposals for national health insurance do not provide ways to assure that our health care delivery system will become more responsive to the causes of poor health among African-Americans.

The American Public Health Association has analyzed eight major proposals before Congress. Their analysis provides a useful way to determine the extent to which proposed health care financing programs would encourage needed changes in health care delivery. Unfortunately, analysis suggests that proposal features that address extent of coverage and financing considerations are significantly more developed than those dealing with improvements in health care delivery. Overall, there is a disturbing lack of specificity concerning enforcement of standards of care in these proposals. Several plans do not address possible mechanisms for planning and evaluating services. The lack of emphasis on preventive health is a worrisome feature because many problems affecting African-Americans can be solved only through effective preventive health measures, including health education. Unless prevention becomes a priority, a national health insurance program is not likely to affect health status significantly.

Other critical features are virtually ignored by the current proposals. Inclusion of minorities as health care workers at all levels and assurances that services will be delivered in a non-discriminatory manner are essential to the development of a health care system that is effective in providing high quality services to African-Americans.

Overall, most of the eight proposed plans for national health insurance before Congress will improve access but will not accomplish major changes in our system of care. It is unrealistic to expect substantial improvements in health status solely through more widespread provision of existing services. Analysis suggests that the definition and scope of health care must change if we are to look forward to future generations of healthy African-Americans.

The major problems facing African-Americans will not be solved by national health insurance. However, national health insurance can provide a basis to begin to develop strategies to change the focus and scope of health care services. It is essential for services to become more responsive to the conditions facing large segments of the

African-American community. These conditions include chronic poverty, limited opportunity and racism. These factors influence many aspects of living, including health.

There are promising models which serve the needs of African-Americans. Many of the problems discussed can be fought most effectively through community-based services which offer support, education and guidance. Community-based services have the potential to be implemented with cultural sensitivity and to provide consumers with the opportunity to work with service providers who understand their concerns. These services encompass a range of programs, including home visiting services for pregnant women and new mothers, community-based AIDS and substance abuse prevention education, and school and community-based violence prevention programs.

Community-based services have been shown to be effective in helping people to change their behavior to minimize health risks. It is essential to develop services that reach African-Americans, including those who live in poverty or are wary of traditional health care.

A method of including essential prevention and support services in the health care delivery system has been developed by Health Management Alternatives (HMA). HMA is the minority-owned company which runs HealthPass, the public Health Insuring Organization (HIO) for Medicaid recipients in South and West Philadelphia, through a contract with the State Department of Public Welfare. HMA has used a share of its profits from this venture to fund community-based outreach and prevention services to improve the health of its members. The initial community outreach and service programs have been targeted to pregnant women and children. Programs funded by HMA include the first middle school-based health program in Philadelphia, home visiting services for new mothers, enhanced prenatal services for women at the time of diagnosis of pregnancy, and Head Start classrooms in the HealthPass area. These are prevention programs, implemented through local organizations, which expand the definition of health care to include social, educational and supportive services, and community service.

The principle of using some of the assets generated through the delivery of health care is a feasible model from which to begin to reform the system. It is not the only possible model, but it represents a workable method for adding prevention and supportive services to the health care delivery system. Whatever method is chosen, it will be essential for universal health insurance to include programs which improve health. If it simply changes the method of financing services, without changing service delivery, national health insurance will have little impact on the lives of the person it serves.

HEALTH CARE COST CONTROL: AN ISSUE FOR THE NATION AND FOR THE AFRICAN-AMERICAN COMMUNITY

Executive Summary

G. Fred DiBona, Jr., Esquire

In recent years, the high cost of health care been a dominant theme in the ongoing debate about the suitability and structure of America's health care delivery system. Indeed, there is overwhelming evidence that the cost of health care in the United States has been prohibitively expensive for a growing percentage of the national population. For African-American, 32.7% of whom lived below the poverty level in 1991, and whose median income of $18,807 is only 60% of the median white household income level of $31,569, the issues of health care cost and access have become critical. The other major issue is the growing number of people who have no health

insurance coverage. Current estimates place this figure at more than 37 million individuals. The conclusion is clear: there is a direct relationship between access to insurance coverage and its cost and, taken together, both issues impact heavily on the African-American community.

In the African-American community, the relative lack of access to health care exacerbates a parallel problem of generally higher health risk as compared to the overall population.

As an example, according to the National Center for Health Statistics, African-Americans are 1.6 times as likely to die from the leading causes of death (heart disease, stroke, cancer, cirrhosis, diabetes, accidents, homicide, suicide, infant mortality and maternal mortality) as are whites.

It is easy to understand therefore, the disproportionately severe impact that high health care costs visit upon the African-American community.

There seems to be a growing consensus on the problem. But there isn't a consensus on the solution. And before we rush into any sweeping, politically driven answer which we may all regret, it would be well to consider some innovations which could guide the debate.

At the outset, I want to stress that these innovations are coming principally from the efforts of Independence Blue Cross and Pennsylvania Blue Shield to meet the pressing needs for coverage and cost control. They are therefore limited at this time to our own subscribers. But I believe they can serve as models in the national debate about shaping a sensible and comprehensive reform of our national system.

With so many young people lacking health insurance, Independence Blue Cross and Pennsylvania Blue Shield have established the Caring Program for Children, which provides basic health insurance coverage to uninsured children of the working poor. In the short time that the program has been in existence, more than 3,000 children in the five county area have been enrolled. And in July of this year, I joined with the Black Clergy of Philadelphia in announcing a three month long campaign in which African-American churches are raising funds to make coverage possible for 200 uninsured children. The coverage is provided at no cost to the recipient since the cost is covered by private tax deductible donations from corporations, foundations, individuals and the Blue Plans. As Dr. Robert K. Ross, Philadelphia's new Health Commissioner noted, "this initiative carries important ramifications for the overall health of our region's young people. According to available research, children who are uninsured generally receive 40 to 50 percent less medical care than children who have health insurance. They receive less preventive care, and their medical treatments are generally postponed, leading to more severe, complicated and costly medical conditions. Programs such as this one help to break that cycle."

Also this year, the five Blue Cross Plans in Pennsylvania and Pennsylvania Blue Shield inaugurated the "Special Care" program which provides basic insurance coverage at reasonable rates for all uninsured who don't qualify for Medical Assistance but earn too little to afford the high premiums for conventional insurance. Since this program was inaugurated in May, nearly 3,800 individuals in the five county region have enrolled in the program.

Also, through its subsidiary, Keystone Health Plan East, Independence Blue Cross allows Health Partners, a voluntary managed care plan for recipients of medical assistance, to enroll employer groups in addition to Medical Assistance recipients. Health Partners, which serves 30,000 members in an area that includes North Central

Northwest, West and Northeast Philadelphia, claims a strong provider network that includes dentists, mental health agencies/providers, substance abuse centers, family planning clinics, home health care agencies, pharmacies/druggists, vision care and ambulance and para-transit services. Each member of Health Partners chooses a primary care physician who makes referrals for specialists or surgical procedures, as necessary. This system has allowed many Health Partners subscribers to have access to their own physician for the first time in their lives. Independence Blue Cross also works in a very similar fashion with Mercy Health Plan, a managed care plan, sponsored by the Sisters of Mercy, serving a comparable predominantly African-American membership.

In an additional effort to offer health care support to the African-American community, IBC has sought to provide information that allows community residents to change improper health habits and to make more informed health-related choices. In that regard, IBC has sponsored health fairs at the Black Family Reunion, at West Oak Lane Community Day Center, at the Spruce Medical Center Community Health Fair and at Simon Recreation Center, among other locations. The company also sponsors an annual Children's Health Fair, wherein students from elementary schools in Philadelphia and surrounding areas are given an array of health testings and screenings and provided test results for later review, at home, with their parents.

Also, in an effort to hold down costs in the interest of our subscribers, Independence Blue Cross is currently negotiating a new hospital contract in which we are seeking "prudent buyer" status. That means that, wherever we are the largest private insurer at a particular hospital, we should get the best rates for our customers. The effect of this initiative should be to bring costs under greater control and encourage the provider community to join us in seeking more innovative ways to manage the system in the future.

Even before these new initiatives were undertaken, however, Independence Blue Cross continued to uphold its historic "social mission" of making insurance available to everyone, without regard to medical condition. We have open enrollment for individual subscribers on a year round basis and turn down no one. Small groups, which are often excluded by private commercial insurers and commercial health maintenance organizations, receive the same open door treatment.

Recommendations

Generally, on the national level, the Blue Cross and Blue Shield Association of America adheres to three simple principles in the great debate now taking place on health care. The first principle is Universality, by which we mean that everyone has a fundamental right to have access to health insurance. The second is Affordability, whereby we endorse stringent measures to hold down costs in an environment where prices are moderated in a system of private competition. The third is what we call Portability. That means that, when you lose your job, move or are transferred, you don't lose your insurance; you carry it with you. According to our Louis Harris Survey, this is of special importance to the African-American community; 45% of African-Americans who said they didn't have insurance gave as the reason the fact that they had lost their jobs or changed employers and had a waiting period to be eligible again.

No one can accurately predict the outcome of the great national debate taking place. But if we keep these principles in mind--universality, affordability and portability--and if our national leaders focus on programs such as we have begun here to meet the needs of the uninsured, then I believe it will finally be possible to reform our health care delivery system by guaranteeing access to coverage, getting costs under control and providing for a private system of competition without undue federal interference.

Such a system, I believe, will be best for the African-American community and for the country and I am pleased to join with the Urban League, our own professional African-American executives at Independence Blue Cross and other leaders in the community in shaping a workable policy for our nation's future.

THE HEALTH STATUS OF AFRICAN-AMERICAN CHILDREN IN PHILADELPHIA

Executive Summary

Robert K. Ross, M.D. and Pamela Keels, M.B.A.

Throughout childhood, African-American youth face many significant challenges to their physical, mental, and emotional health. These challenges have grown in both severity and complexity during the past five to seven years. The result has been numerous preventable illnesses and the deaths of approximately 540 African-American children in each of the past three years.

The myriad problems that threaten the health of African-American children can be grouped into two major categories: access to primary care and violence. Access to quality primary care services is a critical concept in health care. Primary care--including immunizations, preventive screening, good nutrition and accident prevention--provides the key for lifelong health. The inability to access these services jeopardizes the health of the child and decreases chances for a productive adulthood. The second major obstacle to children's health is violence.

The Philadelphia Department of Human Services reports approximately 35,000 open cases of child abuse or neglect. A significant percentage of these cases involve African-American children. In 1989, twenty-seven children in Philadelphia died because of child abuse and neglect. Children who live in violent homes are twice victimized: by the violence perpetrated upon them as well as by witnessing violence perpetrated upon others.

It is said that "poverty is bad for your health". It is well-documented that the root cause of our children's public health problems is poverty. Poverty increases the probability that an individual will live in a neighborhood where there is open drug trade and its related violence. Poverty also negatively impacts on the availability of positive activities (recreation and jobs) for children to decrease the probability of their being involved in a violent incident.

Economics, not race, is the key factor in health behaviors and status. Race as a determining factor in health status relates to the probability of living in poverty.
Our health care system is a disaster. It is complex, expensive, inefficient and emphasizes costly tertiary care rather than prevention. One in eight Americans is uninsured. The current system of providing health insurance coverage is a major obstacle to the health care of our children. Our employer-based insurance system, which does not require all employers to insure all of their employees (or their families), places children's health care at the mercy of their parents and their parents' employer.

Recommendations

- Citizens, health care providers, insurers, employers, and politicians generally agree that children should have guaranteed health care. Disagreement arises around how children should be insured and who should pay to insure them. Health insurance reform will not alleviate the broader effects of poverty. It can prevent additional families from being forced into poverty by medical expenses that accompany a catastrophic illness. Health insurance reform will also assure that children will be able to receive the basic health services they need without stigma and without possibly foregoing quality care.

- As the saying goes, "Idleness is the devil's workshop". Boys and Girls Clubs, sports leagues, music lessons, camps, and other similar positive, organized activities provide children with alternatives to trouble. Positive activities allow children to develop productive interests and skills, and often provide mentors and role models. Through these experiences children gain an understanding and appreciation of themselves and their abilities. When children understand and appreciate themselves, they do gain a healthy respect for others both within and outside of their culture. The most effective drug and violence prevention programs offer recreational and employment opportunities and emphasize self-respect and respect for community.

- Successful youth programs are offered within a culturally-appropriate framework. For African-American youth programs, such as the House of UMOJA Boys Town, project provides Afrocentric rites of passage, surrogate parenting, and violence prevention through conflict resolution. A new program in Philadelphia, the Rites of Passage Shule, offers a curriculum of history, culture, and spirituality, with components focusing on critical thinking, competency and proficiency in communication skills. With parental involvement, sexuality and other health care issues for both boys and girls are stressed. Programs such as these offer a form of holistic youth empowerment. Combined with improved access to preventive health care, we may begin to realize positive change in the health status of our children and our community.

- Our families, churches, and neighborhood organizations must become active in health care issues. We must act cooperatively. Churches and neighborhood organizations can continue to provide more programs that support children and families. These institutions and organizations must also advocate to promote and protect the community's broader health care interests.

- Many churches have rudimentary health care ministries employing a parish nurse or sponsoring health fairs. Health ministries must evolve in local churches. It is critical that these ministries play an important role for congregations.

- Neighborhood organizations have a wealth of resources that can influence legislative leaders and policy makers, determine community standards, initiate and maintain programs, educate our children, and support individual families. Organized groups of concerned citizens must lobby for health care reform and demand improved allocations to programs that benefit our children. Sororities and other women's groups must act as role models for young girls to help them avoid becoming teen mothers or, for those who are already mothers, to help them rear their children, while staying in school. Fraternities, men's groups, and block associations can offer mentoring to steer children away from self-destructive activities.

- Public Health is only beginning to learn to be responsive to the needs of the community it serves. Being responsive means collaborating with churches and

community organizations to establish and maintain neighborhood-based programs. Responsive means supporting legislation that will benefit the health status of children. Responsive also means that African-American health care providers maintain a presence in the African-American community not only as care givers, but also as role models.

Philadelphia as a microcosm of America demonstrates a paradox in health care. Despite a half dozen medical schools, three dozen hospitals, and thousands of health care providers, people of color and the poor in the city suffer from a lack of quality preventive health care. This paradox underscores the social context of health. It also fosters wariness of quick fixes as well as a sense of the limits of what medicine or technology alone can do. This phenomenon is clear in a comparison of the gentle increase in the infant mortality rate and the sharp increase in the rate of low birth weight babies since 1985--the onset of the crack cocaine epidemic. Technology can prevent infant deaths, but too many children enter the world in poor health facing a myriad of barriers to their most basic health care needs. Technology alone cannot keep our children healthy.

An African proverb best sums up this report: "It takes a village to raise a child". The major threats to our children's health, particularly substance abuse and violence, can and must be controlled by our community. Government can provide support,but it should not determine. The community is better able to remember that each "statistic" is a boy named Kevin or a girl named Lisa. It is our responsibility to work individually and collectively to provide the for the health care needs of African-American children. We must understand their current health status and be committed to improving it. It is our community responsibility to give childhood back to our children and to give ourselves a future. We are losing the health of our children in the streets, neighborhoods and communities. We must organize the strength of our neighborhoods to win it back.

INFANT MORTALITY
Executive Summary

Rackell Arum, M.P.H. and Constance Williams, M.S.N.

Infant deaths are a harsh reality of life in Black communities all over the United States. A community's infant death rate is a critical and sensitive measure of the future strength of a people. Infant death rate is defined as the number of babies who die in the first year of life for every 1000 live births. The largest numbers of infant deaths occur during the first 28 days of life.

The infant mortality rate for white Philadelphians in 1990 was 7.9, almost reaching the national goal for the year 2000. By contrast, non-white Philadelphians in that same year experienced 22.1 infant deaths per 1000 live births. The rate of death of non-white Philadelphia infants was more than twice the national goal. Nearly 400 non-white infants died in 1990, the majority of them before the twenty-eighth day of life. In 1990, more non-white Philadelphians lost their lives before their first birthday than did non-whites between the ages of one and twenty-four.

Glaring differences between the health status of non-white infants and white infants are apparent in a number of statistics. Non-white infants are more than twice as likely as white infants to be born at low birth weights. Non-white mothers are over four times more likely to begin prenatal care during the seventh, eighth, or ninth month of pregnancy than are white mothers. Early, consistent, and comprehensive prenatal care is the best measure that a mother can take to have a healthy infant.

Medically, the most common causes of infant deaths are prematurity and low birth weight. Efforts to reduce infant deaths are proceeding along two parallel tracks. First, public health practitioners are committed to improving the likelihood that pregnant women will give birth to healthy babies. And secondly, researchers attempt to advance medicine's ability to care for unhealthy babies. Clearly, medical science is limited in what it alone can do to save the lives of these Philadelphians. The vast majority of infant deaths can be prevented by healthy women having early, consistent, and comprehensive prenatal care. Philadelphia is a community rich in medical resources: six medical schools, dozens of teaching and community hospitals, and academic training programs for virtually every health profession. Pennsylvanians have played leadership roles in national debates about the rights of every American to health services.

The Philadelphia Black Women's Health Project and other advocates see three distinct factors causing high rates of infant deaths in the African-American community: the socio-economic climate in which African-Americans live, issues of access and personal lifestyle and behaviors.

The death of a child before its first birthday is nothing less than a community tragedy. Indeed, some infant deaths are not preventable. With early, consistent, and comprehensive prenatal care, the numbers of African-Americans who are born too soon and too tiny to celebrate a healthy first birthday can be reduced dramatically. Medical science can now save the lives of infants who weigh little more than a birthday cake. It now falls to the community, educational and human service providers and families institutions to create the changes in health policies, service delivery, and personal behaviors that will result in healthy, full-term babies born to healthy mothers.

The image of a child celebrating its first birthday is joyous milestone, one filled with hope. The family tragedy of the death of its infant nothing less than a national tragedy. By working collectively and making appropriate changes in our understanding, approach, and commitment to reducing infant mortality, a greater number of African-American families can celebrate first birthdays.

Recommendations

- The complexity of factors causing infant mortality must be addressed at many levels. To save the lives of the youngest African-Americans, there must be a community-wide commitment, with efforts engaged in on all fronts. Health education, and social policies from the community, health providers, and government, must reflect a genuine determination to save the lives of African-American babies. More of the individuals who shape health policies must be African-American and must be sensitive to the realities of African-American communities.

- The educational system must initiate family life education, beginning with the preschool and extending throughout the school experience. Curricula must be age and culturally appropriate and include such concepts as self-esteem and life planning skills. Personal values, sexual responsibility, preventive health, and parenting must also be integrated into curricula.

- The availability of adequate health care and human service resources is an ongoing issue for pregnant African-American women. Crack cocaine has devastated our community. Despite the clear need for effective treatment, there are very few comprehensive treatment settings available to pregnant women. Some treatment facilities are unwilling or unable to care for pregnant parenting women. Treatment waiting lists for pregnant parenting women are very long. Funding and adequate facilities must be expanded to meet the needs of drug-addicted women.

- Any approach to reducing infant mortality must address the needs of pregnant women in a holistic manner. Her family, her environment, and her culture will influence her health and the health of her newborn. Without incorporating the strengths and the supports of family and community, the efforts of health professionals will be less effective.

- Saving the lives of African-American infants is not merely a challenge to medical science, hospitals, health professions, or public health departments. Working collaboratively and individually, concerned African-Americans must set a community-wide agenda that prioritizes the survival of African-American infants. In our families, our churches, our workplaces, and in our community, African-Americans must do what we can: speaking out on political and social issues affecting the health of mothers; shaping policies; and supporting organizations that are committed to the health of our mothers and infants.

CHILDREN'S HEALTH CARE: A SOCIAL WORK PERSPECTIVE

Executive Summary

Cynthia J. Corbin, MSW, LSW

The health care system in the United States is failing those who need it most. Basic social work values proclaim that adequate, affordable health care is a basic human need. Public policy treats the need for health care as a privilege, to be enjoyed by the special few. Ensuring that health care of all people in this society is a right continues to elude us.

The saddest, most shocking, and most unacceptable aspect of this crisis is its devastating impact on our children. For children, the failure of the American health system to deliver adequate care begins in the womb. It can last a lifetime and the impact is immeasurable. Evidence of this failure is in studies ranging from statistics on infant mortality to variations in life expectancy. As is so often the case in other areas of American life, African-American families, disproportionately experience poor health.

Recommendations

- The National Association of Social Workers (NASW), for example, maintains that we must replace the present expensive, inequitable, and fragmented health and mental health care system with a publicly-financed and administered, single payer health and mental health system. If adopted, the NASW plan will:

  - provide comprehensive health and mental health benefits, including long term care, to every American citizen, while maintaining the current mix of public and private providers;

  - allow health consumers the freedom to choose their doctors, hospitals, and other providers;

  - replace the current patchwork of fifteen hundred private insurers and public programs with a single national health program administered by the states under federal guidelines;

  - pay hospitals a negotiated annual operating budget and reimburse all independent practitioners according to a negotiated fee schedule;

  - eliminate deductibles, copayments and out-of-pocket costs; finance the program with a health premium tax on personal income, an employer paid payroll tax, an increase in corporate taxes, and state contributions.

  Under this proposed system, people would on average spend less than they now spend on health care. Most importantly, all children would receive health care as a right. If not for ourselves, we as a nation and as a people should plan health care reforms for our children.

As the Director of Social Work and Discharge Planning at St. Christopher's Hospital for Children, it is apparent to me that the health needs of the children we care for have changed very little over recent years. Children still need to live in safe environments. They still need routine preventive health services. And they still need the best medical attention when they are ill.

What has changed dramatically are the social conditions in which children are living. Increasingly, Philadelphia children are born into single parent homes, into extreme poverty, and into families that are unable to offer them the safe, nurturing environment that all children need.

The social work profession plays a unique role in educating families about the need for ongoing preventive health care as a necessity for the wellbeing of their children. Social workers have the skills to empower families to negotiate a health care system with largely-negative connotations about uninsured and Medical Assistance-insured. As professionals, social workers can advocate for low-income and minority clients and begin to sensitize health care providers to the needs of poor and minority clients.

HIV/AIDS AND THE AFRICAN-AMERICAN COMMUNITY

Executive Summary

Rashidah Hassan, R.N.

The number of AIDS cases is growing fastest among people of color, especially African-Americans. HIV/AIDS disease was first recognized in 1981 among gay white men. It was not until 1985 that the spread into the African-American community came to light. This community has struggled in confronting this critical health situation. Fear, denial, scarce resources, and limited access to adequate health care and education have allowed this disease to take hold in a community already besieged with enormous social and economic difficulties.

BEBASHI, Blacks Educating Blacks About Sexual Health Issues, was founded in Philadelphia in 1985 as the first organization to provide AIDS prevention education targeted to the African-American community. Other African-American communities across the country responded similarly by establishing community-based organizations that focused on prevention education.

Recommendations

- Community groups and religious institutions must organize to advocate for the development of education and services based on our needs, our language, and our history. Self-empowerment and self-determination are critical in combating this disease.

- A healthier lifestyle must be actively promoted in the African-American community. Every issue that affects our lives impacts our health. We must take drastic measures to communicate explicitly to all segments of our community regarding behavioral risks and to establish an environment that supports and demands responsible sexual behavior regardless of gender or sexual orientation. Messages should reinforce the idea that knowing your HIV antibody status is both a personal and a community obligation. It is our responsibility to find ways to face homophobia, sexism, and promiscuity within our own cultural and historic context.

- We must encourage and advocate for the Philadelphia and the Pennsylvania Departments of Health to implement health promotion projects with community participation.

ALCOHOL AND DRUGS IN THE BLACK COMMUNITY IN PHILADELPHIA

Executive Summary

Thurman Booker, D.O.

Thousands of men and women are smoking cocaine. The devastation wreaked on their individual lives, their families and their children is enormous. Cocaine addiction is merely one aspect of addiction in our communities. Heroin usage has been more noticeable at Eagleville Hospital for the past year. Alcohol remains hidden within the more conspicuous use of other drugs, pushed off the front pages by our greater concern with crime, murder, and neglect. Addiction is multifaceted. It may not be possible to eradicate addiction from society, but we can respond to the needs of the addicted.

Detoxification is the initial period of medical and physical stabilization when medical support and monitoring occurs. The period allows assessment and diagnosis and provides education and motivation of patients for ongoing care. Detoxification is usually brief–lasting three to seven days. If this is the only care provided, there is little chance the suffering person will ultimately recover. Relapse occurs up to 98% of the time, often within hours or days after release from the hospital. Detoxification facilities are most readily available in an emergency. Personnel of these small units must overcome the patient's ignorance, fear and shame and get them into meaningful long-term treatment.

Recommendations

- We need several hundred hospital beds available if we are to reduce the tragedy of epidemic rates of addiction. We also need less intense levels of care available for three to twelve months. Recovery–continued abstinence–requires several months of stabilization and treatment in order to be effective. Halfway houses and, more recently, recovery houses traditionally have been a feature of alcohol treatment. These programs provide supervision, urine surveillance, and support to small groups of residents buttressed by participation in 12 Step programs. Recovery requires a strong base of peer support.

- The poor are at risk for multiple epidemics. AIDS, drugs, tuberculosis, and imprisonment represent only a few of our troubles. We need maternal and child health clinics nationwide. We need inpatient and outpatient addiction programs for women and men. We will need more methadone programs and naltrexone programs for heroin addicts. We need secure funding for AIDS programs targeted to young people and women. We need to ensure the availability of birth control information and the option to terminate unwanted pregnancies. We need school counselling programs that handle a variety of health issues including sexually transmitted diseases, drugs, pregnancy and AIDS.

- When the needs of Black and Latino citizens are perceived as genuine American aspirations, then a major breach in our body politic will have been healed. Until then, our government's response will continue to be inadequate, delayed, and misdirected at best.

- The debate about the merits of decriminalization is likely to be loud and long. I recommend that Mayor Schmoke of Baltimore, an advocate of decriminalization, chair a commission given the task of developing a viable strategy. Treatment must be made available to the general public. Methadone maintenance and the

development of therapeutic communities reduced the heroin epidemic of the 60's and early 70's. A similar opportunity exists for us now.

- Programs for the homeless and chronically mentally-ill persons, those that include case managers assigned to work one-to one with a small number of clients, have been very successful. They lead to more self-sufficient, formerly homeless clients as well as fewer hospitalizations and more timely psychiatric interventions. I propose the development of a similar approach in the treatment of addictive diseases. Generally, addiction treatment is too short to permit actual stabilization of the recovery phase. The interval immediately following discharge is dangerous for most clients, particularly if they return home. Most have to return home. There simply are not enough long-term facilities. A case manager could assist and accompany the recovering client during the first four to six months after leaving treatment, ensure involvement in 12 Step meetings, assist with job interviews, negotiate medical follow-up for chronic and acute illnesses, and facilitate independent living or return to their families.

AFRICAN-AMERICANS WITH SEVERE AND PERSISTENT MENTAL ILLNESS: PERSONS IN NEED OF ATTENTION

Executive Summary

Laurene Finley, PhD

Persons with major mental illness are impaired in their ability to live, learn and work. While severe and persistent mental illness is never cured, the degree of disability can vary from time to time. Biological/physiological, socioeconomic, and psychological factors contribute to severe and persistent mental disorders. Among African-Americans, these factors are compounded by the interplay of unique cultural issues and the status of African-Americans in this country. There are several scientific theories about the causes of major mental illness, though there appears to be no single theory which fully explains the causes of this illness. An inherited susceptibility to the illness may be triggered by the effects of sustained traumatic stress, such as the racism and poverty endured by many African-Americans. Psychological factors may also exacerbate biological susceptibility to mental illness.

Psychological literature has tended, until quite recently, to ignore racial identity as a critical psychological factor in one's overall identity. The mental health system has invariably mirrored the racism of American society and has justified its treatment of Blacks based upon the political tenor of the times.

National surveys on the incidence of mental illnesses continue to report major barriers in the delivery of mental health services to African-Americans. African-Americans in need of mental health services may be overwhelmed by impersonal, culturally-insensitive delivery of services and the insurmountable red tape which must be overcome. Consumers have been "de-raced" and "de-sexed", to be treated as one homogenous group of "mentally ill patients"

Racial discrepancies between Black and white admissions for involuntary commitments are pronounced. Non-white rates are greater for involuntary criminal commitments and for involuntary noncriminal commitment. Dangerousness to self or others– the major criteria for involuntary commitment–may depend on clinical judgements which are readily influenced by stereotypes and prejudices. These decisions

leave considerable room for the intrusion of racial bias. Disparities between the diagnostic assessments of Blacks and Whites continue to be a major issue. Emphasis on African-American inferiority, lack of intelligence and emotional immaturity has often led mental health professionals to diagnose higher rates of hysteria, schizophrenia and impulsive disorders. Blacks have typically been assigned more severe diagnoses such as schizophrenia, while whites are more likely to be diagnosed with the less severe depressive orders. Increasingly, there is, however, more evidence of major affective (mood) disorders among Blacks than has previously been believed.

What has not yet commonly been known or integrated within the psychological and psychiatric literature is that the symptoms of major mental disorders may be variably expressed, with patterns of symptoms determined by other factors such as culture

Psychosocial assessments often do not take into consideration uniquely African-American cultural variables required for accurate diagnoses and the development of effective treatment plans. Issues such as coping styles or simply the identification of what constitutes "family" resources are two examples of cultural considerations not integrated into assessments of the mental health needs of African-American clients.

Black culture places an emphasis early in life on the ability to survive in the midst of adversity, against all odds. African-American culture has supported the management of situations without showing stress, to be "cool" under fire. The African-American culture sanctions families need to seek help for social or financial needs through both family and social agencies By contrast, for psychological issues, the culture sanctions the ability to survive and to handle one's problems alone. Black behavior has tended to baffle middle-class mental health professionals, who have been unable to recognize culturally distinct behaviors and unique coping mechanisms Racial, cultural and class variables are neither acknowledged nor integrated into assessments of mental health needs.

Recommendations

- There is a desperate need to formulate the specific attitudes, knowledge and skill competencies required by mental health providers to work effectively with African-Americans. Only by demonstrating competencies across these three skill areas can providers and Black institutions such as the Urban League hold providers and the mental health system accountable for treatment of African-American consumers.

- Philadelphia Office of Mental Health administrative staff, program analysts, and developers of policy and planning require specialized training in order to assist them in identifying more accurately not only the service needs and barriers for African-Americans but the required program components of mental health services which are culturally compatible with African-Americans

- A two-pronged strategy to service development should be considered One strategy would assist African-American consumers in better accessing, understanding and utilizing existing services What this may require is the implementation of consumer education models These models, sometimes with the aid of videotape, explain the services, give information to the Black consumer on the types and process of treatment, and correct stereotypes of treatment

- Afrocentric service models, still in their developmental stages, are worthy areas of exploration.

- There have been examples of experimental service models designed to impact Black consumer self-esteem and to promote engagement in mental health treatment. These models incorporate and foster curative healing factors by creating a foundation for therapeutic safety in being with others who are also like them, through empowerment, through demonstrating responsibility for others, through facilitating cohesiveness through the sharing of common, mutual concerns, and by developing problem-solving strategies. Among these are rites of passage models aimed at recapturing high-risk African-American youth through the integration of African traditions into treatment strategies. Such models may well have implications for African-Americans with severe and persistent mental illnesses.

- It is recommended that mental health service utilization rates of African-Americans be used to develop specific strategies to impact the delivery of services. Exploration of underlying reasons for differential service delivery must be conducted and addressed. Secondly, program analysis require more specific guidelines which may assist programs in better meeting the diverse needs of the consumers. Thirdly, service treatment plans conducted by providers must begin to reflect culturally-appropriate goals and treatment methods.

- The physical environment of mental health service providers should also be reflective of African-American culture.

- Boards of directors of mental health agencies should represent family members, consumers as well as members of the African-American community. Agency administrative staff representation is also important.

- Community interest in the issues and needs of persons with severe and persistent mental illness is required. Community monitoring of the practices of the Philadelphia Office of Mental Health by a Community Advisory Board would be useful in keeping the needs of African-Americans with mental illness in the forefront.

ORGANIZED LABOR PERSPECTIVE ON THE STATUS OF AFRICAN-AMERICAN HEALTH
Executive Summary

Henry Nicholas

An advertiser for an over-the-counter cold and flu medication chose an old adage from the Black community as the basis for a television commercial. The thirty-second spot illustrates the comparative size of a cold to the flu. The former is small, the latter is huge. Tragically, the source of the advertisement remains literally and figuratively true in Philadelphia. If America catches a cold, the Black community catches pneumonia.

The inability to purchase health care afflicts even the ranks of those who labor. They, too, cannot keep up with or catch up with upward-spiralling health care costs. Many who work in service positions have little or no health insurance, leaving them in a worse position than those who rely on public assistance and Medical Assistance

Consider also the plight of health care workers in this City. Many, to paraphrase Reverend Jesse Jackson, cannot afford care in the health care institutions where they work. Too many health care workers are among the growing number of Philadelphia-area employees are among the growing numbers of those whose health care options are threatened by layoffs, cutbacks and givebacks.

Over the past decade, the ten thousand health care workers represented by District 1199C have anticipated the health care crisis in which we now find ourselves. Using the strength of their organized numbers, the members of District 1199C have addressed health care issues affecting themselves, the patients they care for, and the community as a whole.

Recommendations

- National health insurance and access to care is not just the battle of organized labor. It is everyone's battle. There can be no divisions among groups attempting to solve the health care crisis and to alleviate the suffering of Black Philadelphians. Health care for the people is an unacceptable arena for political football players or posturing politicians of any party. Health care is not, and cannot be, a luxury or a privilege.

Philadelphia—and indeed the nation—is at a crossroad. The lives and health of Philadelphians must not be compromised. The worsening health crisis has been apparent for many years. Now the confrontation is joined. Employers, health institutions, insurance companies all must share in the shame. While costs escalate, employer proposals of benefit reductions threaten to deepen the abyss into which thousands of Philadelphians would fall.

Responsible leadership from every segment of our community must convene and thoughtfully consider the health care crisis. Collectively, workers and management are equal to the challenge. The health of this great City is in the balance, precipitously suspended by a thread.

PENNSYLVANIA CONFERENCE ON AFRICAN-AMERICAN AND MINORITY HEALTH ISSUES
January 8 through 11, 1992

Executive Summary

State Representative David P. Richardson, Jr.
Conference Convener

Americans of African descent continue to suffer from the legacy of slavery and the remnants of institutionalized racism in the United States. One need only review the dismal comparative statistics in the areas of education, employment, housing and economic development to understand the severity of this situation. These statistics pale with those portraying the physical and emotional wellbeing of African-Americans. Similarly, other minority groups suffer disproportionately major, life-threatening illnesses and conditions. Moreover, there are major gaps in the delivery of and access to health care for African-Americans, other minority groups and the general population.

To address the myriad health issues facing Pennsylvania's African-Americans and minority citizens, I convened a statewide conference in January, 1992. In attendance were health professionals, advocates and consumers. The policy statements and recommendations presented in this report represent the proceedings of that conference. This report was submitted to the Governor for implementation by state departments.

Recommendations spoke to the need for the Commonwealth to develop culturally-sensitive programming to address the unique health needs of African-American and minority Pennsylvanians. Key recommendations were for the formation of an Office of Minority Health and the use of the conference format to review progress in meeting health needs.

THE POLITICAL ECONOMY OF HEALTH:

IMPLICATIONS FOR AFRICAN-AMERICAN LEADERSHIP IN PHILADELPHIA

Executive Summary

Thaddeus P. Mathis, Ph. D.

The report has been guided by a concept of health somewhat broader than the conventional understanding of health as the mere absence of disease or injury. Such an expanded view, hopefully, has generated a more accurate understanding of the barriers to access to the health care system for large segments of the African American community, as well as the means by which a large number of African Americans are excluded from adequate health care services.

Furthermore, the articles in this report are written from a diversity of perspectives However, taken as a whole, the report contributes to what might be characterized as an evolving Afrocentric political economy perspective on health and health care services As such, it provides a potential basis for assessing the performance of African American public policy leadership in the city. To the extent that health deals with more than the mere absence of injury or disease, it might be said that African Americans in Philadelphia exist, for the most part, in a state of healthlessness, meaning that they exist amidst a set of social conditions that are hazardous to their health.

One indication of the health of a community is the extent and efficiency with which it is able to reproduce itself. In this context, one of the more striking observations about the African American community at the end of the 20th century is its ethnic and cultural diversity, as well as its increased economic and social differentiation.

One contributing factor to this diversity has been increased interracial interaction For example, the number of interracial marriages involving African Americans more than tripled during the past two decades In addition to cultural continuity, another indicator of health status is the condition of the family unit. In this regard, another outstanding characteristic of the African American community in this period is the increased number of single-parent families, particularly those headed by women. Seventy-eight percent of all African American families contained two parents in the home in 1960. In 1990, only thirty-seven percent of African American families were two-parent households. By 1977, approximately one hundred thousand African American children were being placed outside the home in foster care. Another thirteen thousand were placed through adoption, many of these in non-African American homes. These numbers have increased even more dramatically since that time

In addition to family status the rate of institutionalization may also be viewed as a measure of community health On this measure as well, the experiences of African

Americans reflect a condition of healthlessness. The rate of impoverishment is another indicator of community healthlessness and the breeding ground for future bad health. Finally, the emotional health of a community may be gauged by examining the degree of alienation as reflected in rates of homicide, suicide, and drug addiction. In this context nationally, homicide and suicide have become two of the leading indicators of African American healthlessness.

Given the degree of African American individual, family and community healthlessness, what relief is available? The short, sad answer to this question is: Very little. The American health care system, in general, is shaped and maintained by an extensive system of cultural and class factors. Health care in the United States, for the most part, exists as a commodity, to be bought and sold on the market. It has assumed the major characteristics of a market commodity in its cost structure, availability, and its degree of specialization. These dynamics significantly determine who will be served, the choice of treatment modality, the duration of treatment, and the quality of personnel assigned to perform the treatment. In all these circumstances—access, accountability and suitability of services—African Americans fare worse than their white counterparts. Approximately thirty-three million Americans have no health care coverage at all and another fifty million have only partial insurance. As recently as 1983, only forty-four percent of African Americans who received health care received it from a private physician in his/her office; 26.5% in a hospital emergency room, and 9.7% in outpatient clinics. The corresponding rates for whites were fifty-seven, thirteen, and sixteen percent respectively.

Furthermore, African Americans constitute 13.7% of the work disabled population in the U. S. Only thirty-seven percent of this group is covered by Medicaid. Even those who are covered by Medicaid often find themselves discriminated against in other aspects of the health care market, for example, in differential access to nursing care facilities. Finally, not only are African Americans victimized by current conditions, but projections are that the situation will worsen as the so-called baby-boom-generation reaches full maturity.

Recommendations

- Our approach to health must be different. We cannot continue to rely exclusively on medical technology, or payment schemes, or even new treatment techniques to improve the quality of African American health. For many problems confronting African Americans these remedies are insufficient. The cure for alienation, for example, is not just medication or drugs. The cure for loneliness and depression is not just counseling or therapy, but organized social movement and struggle. Men and women joined together in life-affirming struggle have little difficulty bonding and little time for narcissism or other self-absorbed reflection. Getting by or staying high can no longer be tolerated as acceptable responses to our oppression. We must resist and resist actively and collectively. It is the responsibility of our leadership, at all levels, to show the way.

- The lack of a comprehensive, coordinated, and consensus-based planning and policy system within the African-American community continues to plague us, not only in the area of health, but in all areas of social policy development. I propose that the Institute for African American Development support the development of decision-making, policy-deliberating, planning mechanisms needed for African-Americans to gain control over the processes of self-development in our community, from health to politics. This effort would include the identification and organization of those who wish to provide leadership to the African-American community. Through an organized process, the Institute would facilitate the development of a community consensus, an African-American agenda, to be used as an organizing, political action, and development tool to advance the interests of the masses of African-American people in the Philadelphia area.

[Whereupon, at 12:07 p.m., the committee adjourned.]

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