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# Health Priorities: Unfinished Problems and New Challenges

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It is a pleasure and a privilege to participate in these deliberations coming at a time when a new building takes form and a great international center for public health is beginning to emerge. My brief comments this morning address some of the major changes which have occurred over recent decades and which contribute to the challenges you will be facing over the years ahead.

During the past 25 years, most notably during the past decade, we have witnessed truly revolutionary changes in health, especially in many middle- and lower-income countries. While we devote a great deal of attention to analysis of immediate unmet needs and of near term opportunities, few comprehend just how much has already changed and how rapidly. And, what this implies for future health programs and policies.

I would remind you that only twenty years ago, national family planning programs were barely out of the cradle (if you'll pardon the expression) and historical accounts of those programs, even those of the late 1960s, reveal them to have been unbelievably primitive by comparison with today. Until the 1980s, immunization, save for the smallpox and BCG vaccines, was uncommon and the now widely prevalent diarrheal disease programs had not even been conceived. There are others. What is important to stress is that a number of important new preventative initiatives have been taken in what we call community-based programs and the changes have been profound. In Latin America, for example, fertility rates have dropped by 50% in less than thirty years and, during this period, mortality rates have fallen at rates of 10-30% every five years. The community-based program cannot take credit for all of

the change but they have made major contributions and promise to contribute more.

The result is an epidemiologic and demographic revolution of a magnitude and at a pace never before witnessed. Within 25 years, Latin America is forecast to have an older adult population, i.e., individuals who are 45-64 years of age, which is 2-1/2 times larger than at present. Older people, like older machinery, have many parts which wear out and others which become dysfunctional, especially if they have been misused. They will want them repaired or cured or seen to in some manner. Added provisions for sickness care will be needed for this. Predictably, this larger body of older citizens will have substantial political weight and inevitably, there will be pressures to allocate or reallocate resources to provide such facilities. But how many treatment facilities, based on today's model, can be provided and at what cost?

It is natural to look to other countries who have treated proportionately larger numbers of older citizens and to model facilities and systems based on their experience. Take the U.S. sickness care system as but one example, but examine it for what it is. Health care expenditures this year will approximate $600 billion, more than $2,500 per person. That the U.S. model is not of great relevance is perhaps best appreciated when one realizes that this expenditure is now twice the total gross national product of China, a country with four times the U.S. population. Expenditures per capita in the United Kingdom or Canada or Scandinavia are less but not that much less - certainly not in terms of orders of magnitude. The bottom line, quite simply, is that existing practices and systems for providing sickness care will prove far too costly and doubtfully appropriate to the inevitable realities which middle-income countries will soon face. Indeed, only very gradually are we coming to the realization in our own country that to make available unlimited quantities of sickness care to all persons by individual craftsmen (i.e., doctors) is a luxury which we basically are not prepared to pay. In the U.S., thirty five million uninsured are moot testimony to this.

What to do poses a challenge to health and medicine which we have never before confronted. Surprisingly, this quandary even today, is little appreciated by the public and infrequently discussed by the medical profession. Given that we can't simply muddle on indefinitely as we have, what solutions are possible? I see only four and some mix of these will radically redefine health and medicine by the end of the decade.

1. Invent/devise a wide range of magical new medical bullets/devices for treatment or rehabilitation which are vastly more cost-effective than available treatments. The basic hope in so doing would be that far more people could be treated at lower cost. If you believe that this is a potential solution, you are one who is optimist enough to believe that the U.S. could win the World Cup in 1994.

2. Ration services in some sort of equitable and reasonable manner. Even now, every country is actually doing this, implicitly or explicitly, through failure to provide services to the poor and less accessible or through waiting lists, etc. Unquestionably, this will continue to be done and perhaps with better technology assessment, rationing may be more rational. It is a formidable challenge, however, to ration health care within a politically acceptable framework taking into account valid concerns of ethics and equity.

3. Reduce service costs by more economical larger-scale operations and by permitting services to be given by providers more appropriately trained for the task.

   You don't today expect to buy a piece of jewelry designed to your personal specifications nor do you expect someone with a degree in computer science to operate the local cash register. However, such analogous and inappropriate uses of manpower pertain in medicine and these practices remain, in large measure, a precept

of what many argue constitutes good medical practice. In part, because of this, the concept, for example, of large-scale immunization programs, in which vaccinations are administered by persons other than physicians and nurses, has been resisted on every continent. Yet, when these have been well-conducted, they have proved highly effective. Might we visualize lower-cost assembly-line type cataract or hernia programs, for example? They are being tried. Might we make an effort to demystify medicine and let many more persons take a greater responsibility for their own health? After all, there are many who now do complicated repairs of their own automobiles. The bottom line is that if we expect to provide affordable health care services, a serious reorientation in health care is required within the coming decade from what still is a service provided by medieval guilds which, consciously or otherwise, make little effort to delegate responsibility or to demystify their practices.

4. The last option is to endeavor to keep the human machine functioning in better, if not good health so long as possible. This has been and indeed still remains a substantially unexploited area. Take vaccination, for example - the most cost-effective, simplest medical procedure we have - but, until a decade ago, it was all but ignored in most middle- and lower-income countries. And, in the U.S. today, the costs for this procedure are not covered by most insurance schemes and so-called Health Maintenance Organizations. We could and should have not less than ten new antigens in universal use within the decade but, barring a major reorientation of our priorities, we won't! Why? The focus of political concern and interest remains sickness care and the development of larger, more elaborate sickness-care systems. We could discuss other preventive initiatives of the highest priority - actions to combat tobacco induced disease, drug addiction, lead poisoning. These, however, are of high priority because so many of these lead to premature human illness and longer-term stress to the sickness-care system.

Note that each of these options will require a quantum shift in non-conventional practices and a substantial reallocation of resources. We need to address what these could or should be and how they might be implemented and evaluated. In doing so, we need to bear in mind that revolutionary changes in fertility and in health have already occurred and these, in turn, now call for even more revolutionary changes in our thinking about the future of health and medicine. Future possible scenarios are as difficult to visualize and generally unthinkable as "global warming" and "nuclear winter" but the time has come when we have no choice but to look seriously at these options even though they require a reconceptualization of health and medical practice.