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The Nation's Health: What of the Future

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I join you and this distinguished group of panelists with some trepidation. In my experience, nothing is quite so difficult to come to grips with than one's own murky crystal ball. Even a Dean's favorite problems, such as parking and space, I find to be less problematic - perhaps because one knows from the outset that those are insoluble problems.

There are those who would categorize and file most important issues of health in the same insoluble basket of issues given the nature of our pluralistic health system (a sort of euphemism, of course, for an anarchic sickness care organization); the constraints in funding (unless perhaps we were to merge the hospitals with the S. and L. industry); the clearly insatiable, ever-growing demand for ever more expensive sickness care; issues of quality and appropriateness of care; and the not unrealistic premise that AIDS, as serious a problem as it is, may not be the last nor perhaps the most serious of challenges which infectious agents may present. There are no simple solutions to challenges so complex as these.

Although I am optimistic that there are answers, I'm unable to offer global solutions. In fact, I find it difficult to get my arms around the problem satisfactorily. It seems to me that we need to begin by the reshaping of institutions which can create and manage change and the development of people with skills to do so

manage change and the development of people with skills to do so within a framework of community health. I accept the challenge to be provocative and will offer an approach.

If I may digress briefly, my ruminations over future scenarios in health began in ernest during my years with WHO and the frequent, insufferably tedious field trips across desert and open savannah. I entertained myself, if indeed 'entertained' is the proper word, with one question. Given the powers of a Minister of Health in a fairly autocratic state, what would I do to enhance the health status of that nation? More resources was an obvious answer, but what was apparent everywhere was the fact that there already was a substantial, greatly under-utilized health staff, almost all of whom were engaged in providing curative services - to the extent they had anything to offer and even if they didn't - to great hordes of people who appeared daily at a primary health center. There was essentially no supervision and, if there had been, it's uncertain what a supervisor would have done. There were no standards against which to measure performance in treating patients. Whether they were having any effect whatsoever on the health of the community at large was a total unknown, but that didn't seem to trouble anyone. Few data were being collected regarding illness; death registration was all but unknown, and such information as was obtained to satisfy the bureaucracy was simply filed away in a dusty statistical office. Given the sorry circumstances, what could one do?

My thoughts drifted from resources to better, more appropriate training, and this indeed was one of the great panaceas being funded by all manner of foundations and assistance agencies. But one soon came to appreciate that one was dealing with a monolith - a vast, deeply ingrained culture of often inaccessible and ineffectively administered sickness care, an educational tradition to support it and a bureaucracy thoroughly schooled in its mechanics. Whatever one's authority, I couldn't envisage how one could possibly re-direct resources and energies toward totally alien goals couched in terms of the health of the community. In brief, it seemed that the systems were irreparably broken - that one couldn't get anywhere from where one was at the present.

Now none of us would suggest that the health system in the U.S. bears any similarities to what I am talking about. Certainly not, except as we now probe to discover why measles incidence has increased six-fold in the U.S. in only two years and recorded deaths are higher than in two decades, we discover that the problem is not that of disinterested, ignorant parents nor lack of availability of vaccine. Rather, we discover an immunization program in which all manner of barriers have been erected to deter access ranging from inconvenient hours of clinics, failure or refusal to vaccinate children seen for other conditions and requirements by most third-party insurance agents and, indeed, some HMOs that immunization be paid for by the patient. This is a curious state of affairs given that vaccination represents the single most cost-effective procedure in our medical armamentarium

and the simplest to apply. If a health system cannot deliver the simplest of services, what does it say about its ability to provide more sophisticated services?

For the third world, we began an effort which we hoped would cause health staff to begin (emphasize begin) to concern itself with illness in the community at large; which would embrace standards of performance and, thereby, permit supervision; which would use disease data to assess strategy and to allocate resources; which would educate a wider populace to encourage demand; and which would have characteristics of a more consumer-friendly system. Thus, a program of immunization came into being which would measure performance by disease occurrence and vaccine coverage and which would make the vaccines available at convenient times and places. Our hope was that, in time, other interventions would be added. And some now have. Resistance has been high, however. Many simply cannot conceive of any medical intervention except in the context of one-on-one patient-physician encounter. Traditional health services and staff participate, but other community workers and agencies now also play a role in a diverse array of program strategies best suited to local needs. Interestingly, the most difficult problem has been and continues to be that of establishing data collection systems and then persuading the M.D.s/the program managers to use those data in deciding priorities and in allocating resources. Let's face it. In the medical field, we have been and remain numerically illiterate.

Immunization represents, of course, only one health intervention and indeed a special type of procedure in the medical armamentarium. However, it most clearly illustrates for me a likely point of departure - the principle of a focus on the health of the community, and continuing measurement of this rather than on the outcome of illnesses on individuals who present themselves to a sickness care facility and the allocation of resources more optimally to do so. In creating "Health Goals for the Nation," we have begun such a process. What is lacking, however, is a suitable structure and mechanism for designing strategies, for monitoring progress, for re-allocating resources and for making crucial policy decisions. Health departments cannot do this alone given the fact that they are thinly staffed and are responsible for only the smallest mite of all resources being expended for health care. State and federal agencies can play a role in defining broader agendas and in initiating some national education initiatives, but it is difficult to conceive of any set of federal regulations or reimbursement schemes of the traditional mold which would make a meaningful difference.

Perhaps the time has come to reassess our strengths and to determine how best to build upon these. There is no disputing the fact that for those who have access, this country can provide superb sophisticated care and has a preeminent biomedical research structure. Our primary strength in biomedicine resides in the large medical centers, primarily the academic health centers. Their responsibilities and their mission to date have been to

provide the best in sickness care to those who present themselves and to advance the state of medical knowledge. To carry out this mission they are, as you know, heavily reliant on federal and state funds - be it Medicare, Medicaid or NIH grants.

None of these Centers, however, bear responsibility, except in the most indirect manner, for the health of the communities in which they are situated. They are not expected to do this and they are not supported to do so. Conceptually, that responsibility rests with state and local health agencies and, for preventive services, they in turn derive policy guidance and support at the federal level, primarily from CDC. For all intents and purposes the agencies, as well as CDC, might as well be on a different planet. Does this make sense?

One of the forces now beginning to shape our future rests in the premise that industry and academia working more closely together could achieve much more than either alone - and experience is affirming that belief. Efforts are also in progress to strengthen ties between academia and the federal laboratories - again with encouraging results. Is this not the time to embark on a series of initiatives to induce the large medical centers to take a lead with federal, state and local health agencies in developing programs most appropriate to the communities in which they are located - community-based programs? Might this eventually lead to the possible development of global health budgets for the whole of a region - with priorities decided by those resident in the area concerned?

The responses of academic centers, and indeed their structures, are highly sensitive to the availability of resources - and of that I can offer personal assurances. Some have doubted that they could or would undertake a service function such as this. In fact, they already do manage an enormous service enterprise - the hospital - and many in fact, manage large HMOs. Why not enlist these talents by broadening their mission to serve a broader public health function?

On the surface this may appear to be a radical departure from our present method of functioning, but, in fact, a model embracing a number of the relevant characteristics already exists - in agriculture. It is a model which has been widely lauded - and widely copied - for its success in creating the formidable agricultural engine we now have. The land-grant colleges are at the heart of the system, undertaking data collection and analysis, providing continuing education, advancing a research agenda and relating all of this to the community through a vast network of agriculture extension agents. I wonder how many of us here know anything of that model or have studied it carefully for its possible applications to health.