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SUMMARY REMARKS

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SUMMARY REMARKS*

In endeavoring to offer an all too modest summary for this wide-ranging symposium, I would like to make a few observations and then offer some thoughts as to the future. We have been presented with an immense amount of data depicting a diverse array of problems but, ultimately, my concern returns to the question of what we are going to do to address the problems. Let me offer a few personal thoughts.

I am sure you would all agree that the last two days have encompassed a very rich and diverse array of material. The presentations have properly focussed on the root causes of our most pervasive and serious health problems, on those associated with minority groups, on the widespread pernicious effects of disguised or unrecognized racism and on poverty and economic depravation. No one in a brief summary such as this, and especially at a time when blood glucose levels are low, can possibly provide a proper summary which embraces the essence of all presentations across the vast spectrum embraced by the symposium.

It seems to me that we are entering an era which will have a profound effect on countries and peoples, an era marked by a new awakening to social challenges, by an awareness of differences between peoples and differences in cultures, religions and social disparities. Regrettably so far, an undue emphasis has been placed on that which divides and differentiates, on fear, on historical and religious animosities extending back over centuries and millennia, on attributes which distinguish one group over another.

This, as is all too apparent, can serve to destroy peoples and the fabric of life itself, as it is now doing in countries as diverse as Yugoslavia, Lebanon, Kenya, Northern Ireland, Israel, Peru, Sudan and Ethiopia.

In this country we are likewise increasingly aware of racial and cultural differences. This recognition could likewise be very disruptive; and could adversely affect the United States or, in recognizing and appreciating the rich diversity of America it could be constructive. It depends on how we view the differences. We have been reminded, properly, that to document health problems by aggregate groups such as Blacks and Asians and native American minorities is in fact simplistic and naive. We know that Asians from Vietnam and Laos have very different characteristics and cultural values; those from Japan vary greatly from those raised in the Philippines and; as our speakers have pointed out, native Americans and Blacks are not each some grand homogenous group to be characterized by an averaging statistic. Moreover, as the presenters have implicity reminded us, we are not going to solve problems with a single prescriptive national program. I believe we are in accord that it is unrealistic to suggest that symptomatically similar health problems can be addressed in a like manner among residents in Harlem, in Appalachia, or among native Americas in Alaska. Happily, we have come to appreciate that the fabric of our society is a complex one and that fundamental approaches to social problems, including those of health, must be specific to local areas. There are no simple silver bullets that are going to right injustice, abolish substance abuse, or deal with high infant mortality.

In a time both of great divisiveness and a growing appreciation of differences, I would submit that perhaps the most important and catalytic force which could abet and foster needed mutual respect and accommodation between groups are programs directed toward the improvement of health. Of all the sectors, health certainly is the least controversial. In the many different countries and areas in which I have worked, I have found that when peoples have joined together to devise solutions to attack critical health problems, diverse, even hostile groups have been able to unite in a common cause and in the course of so doing, have built a mutual respect which have permitted other issues to be addressed as well.

A vivid academic example for me was a Johns Hopkins project involving a toxic waste dump, a project which included professors in biostatistics, epidemiology, toxicology and behavioral sciences. On return from work in the field they went out of their way to tell me what remarkable, knowledgeable colleagues they had, and that, for the first time, they had really appreciated what the other disciplines had to contribute. Around a common problem, they saw things in a new and very different light. To all of us who were privileged to work in the smallpox program and later in some of the community-based programs overseas, it was a simple truth such as this which more often reveals itself in a foreign setting but which often takes a while to appreciate in a domestic setting.

Let me offer a few other personal experiences. One of the most notable occurred as the Smallpox Eradication Program began. Officials of the Soviet Union believed that since they had proposed Small Eradication -- which they did -- that there should be a Soviet Director of the Program. The Soviets and the Americans at that time were on anything but good terms but it was decided by the Director General to designate an American. The reason, in part, was that he did not think the program could possibly succeed; he blamed the United States for joining with the Russians in launching it; and, thus, he wanted an American holding the bag with WHO when the program failed. For me, this was an auspicious beginning! After a year, the Soviet Vice Minister came to me and said that they had decided I was not "political" and that I really wanted to see the job done. Accordingly, he said, you have our full cooperation. From then on, we worked very closely with the Soviet Union, with myself actually going to Moscow to interview and recruit Soviet candidates. We got some excellent people and they contributed greatly. We received in all more than a billion doses of vaccine from the Soviet Union, almost without publicity. Sometimes difficult problems had to be solved. Soon after the program began, we discovered a number of lots of Soviet vaccine of substandard potency. I was cautioned not to mention this to the Soviets as it would create no end of potential troubles. Despite this advice, I flew to Moscow, sat down with Ministry officials and described the problem. They expressed great concern as well as appreciation for being informed. They thoroughly investigated the situation and closed several production facilities. We never had trouble with the vaccine again. Integrity and honesty in trying to achieve an objective can accomplish a lot.

During the course of the program, we even found it possible to work with rebel groups in Sudan, in Ethiopia, in Nigeria and in Somalia. Smallpox staff were able to sit down with rebel leaders, discuss the health issues, devise a strategy and indeed gain their full cooperation in a program where the opposing forces could not otherwise communicate at all. Most recently, during the immunization program in the Americas, we witnessed in El Salvador, during the worst of the fighting, three days of truce each year when all fighting stopped and teams went out and vaccinated children. In the health field we have opportunities that one does not have in other sectors of our economy. I believe this pertains today and in America as well.

One of the most creative steps in health in recent years is the development of the Year 2000 Objectives. They define a direction. They give us landmarks. For every community, they identify objectives and actions which need to be taken. Health is like politics. It is a local issue, and as we have been forcefully reminded during this Conference, it has local solutions. The basic question which I have asked of many groups is an obvious one -- "Can we possibly bring together a diverse array of people in a community including state and local health department staff, the Federal government, academic health centers, community leaders, professionals, and so forth to look at a set of problems, to decide on objectives, develop strategies and, finally, working together, to achieve these objectives?"

Personally I believe this can be done and in a few areas such steps are being taken. The concept sounds idealistic and, unquestionably, it is difficult to realize, but I believe it can be done. Indeed, it is the only practical approach i can visualize. Will it solve all the problems? No. But if we can learn to work together with a diverse group on one or a few objectives, I believe we can extend the approaches out to produce a broader product.

I believe that one can involve even health centers in this activity. We have a plethora of health centers extending across the United States. But how many health centers, including the one down the street at Emory or my old health center at Hopkins, are directly concerned with the health of the community in which they are based? In fact, few indeed. The reason is simple. Health centers are not basically concerned with health. They are concerned with sickness. They are concerned with those who are sick in the community and who come in to be treated. They are sickness care centers operating in a sickness care system, not a health care system. I frequently remind our colleagues who direct academic health centers that if they are to be so named, they should be responsible for what their name says they are responsible and concern themselves with the health of the people at least in their own community.

A health system and health initiatives require a broadly collaborative effort involving many different groups and skills working at the grass roots. Professional

medical involvement is necessary but the role must be a contributory one; it alone is not the answer.

Three principles are important if we are to make progress in addressing the health of the community. I offer them for what they are worth.

First we need to have a mechanims to define the problem. We need a surveillance system. If we are going to have objectives, we have got to know the prevalence of disease in an area and we have to have some way of measuring incidence so as to know whether we are making progress. This sounds very simple and straight forward. National statistics are interesting and helpful but local data are what we need. But in medicine, we have remained basically illiterate, numerically. Specifically, data regarding numbers of cases of disease and numbers of deaths and their cause are incomplete, slow to be reported and generally ignored. Why? Because we do not use such data for allocation of resources. We do not use such data for monitoring programs.

Many say it is too difficult to obtain and assemble such data. Other sectors, however, do so on a routine basis. I have always been impressed when I peruse agricultural statistics. One can learn how many cows there are in each county, how many gallons of milk on average each produces, how many acres are planted in wheat and soy beans, how many bushels were produced each year. There is an incredible array

of local data dealing with agriculture. If one looks for data regarding IBM, one finds that in every major brokerage house, there are two or three people specializing in IBM, plotting sales by day, by area, by type of equipment and so forth, and all of this feeds into a decision as to whether one buys or sells IBM stock. This is, of course, aside from the army of statisticians and analysts at IBM itself. We do not pretend to collect such data for health. Of course, it is only a matter of life and death.

A second principle is that surveillance systems be effectively employed in program management. Surveillance systems provide the mechanism by which groups can identify problems and determine the progress being made in addressing them. Use of such data requires that strategies and tactics evolve and change in response to progress or the lack thereof. It must be a dynamic system. Too many health programs, as I have seen them, are basically stagnant. Once established, they have continued mindlessly in the same mold as they were originally conceived with little thought as to whether progress is being made. New programs have simply been layered on older programs. Paul told us that he has 46 categorical programs, not necessarily related one to the other. Planning and flexibility are required to permit such programs to be appropriately developed, joined or related.

As we look to the future, we need to learn to monitor more than inputs to programs. We need outcome measurements. If one is constantly examining outcomes and measuring progress in achieving a target, if the responsible group develops a

passionate dedication to the achievement of an objective, everything changes. A lot becomes possible. To illustrate for you a very recent experience, I would cite the global program on immunization in which for 12 years the program functioned without a surveillance system. Those managing the programs said that they were so busy giving vaccine and counting the numbers of vaccinations given that they could not collect data on illness. Finally, in 1986, a surveillance system for polio was first established in Latin America. What did they find? Many cases of polio due to type 3. This was strange as one does not usually see a predominance of cases due to type 3. Many of the children had been vaccinated. Investigations proceeded to assess vaccine performance in terms of antibody response. The response was poor. However, if one doubled the quantity of the type 3 component in the trivalent vaccine, one obtained an adequate response, say 80 to 85 percent. With the amount then in use, the response was about 40 percent. However, this was the same vaccine that had been used for 25 years. It was satisfactory for temperate climates but in the tropics, it performed badly. One wonders as to how many other public health programs might reveal similar findings if we undertook to obtain outcome measurements.

Finally, to address a problem raised by one of the audience, there is a third important component to which we need to pay attention. It is captured in the simple phrase, "consumer satisfaction"--a user-friendly system. Every successful industry has been characterized by a concern for producing a product which the consumer wants and delivering it in a convenient, attractive manner. The one prevalent exception to this is

medicine. Too many of those engaged in the practice of medicine operate on the implicit premise that the patient is available for the convenience of the physician, not that the physician is there for the convenience of the patient. As you know, this extends across the board from the hospitals, to the private physicians, to public health. Medicine has remained all but oblivious to the simple principle that to have an effective system, one has to pay attention to the consumer and to design a system which provides consumer satisfaction.

This past year I chaired the National Vaccine Advisory Commission in a review of causes of the recent measles epidemics. What did we find? We found that immunization in this country, particularly in inner cities were, at best, in the range of 50 percent for preschool children. It seemed inconceivable that with the numbers of physicians and hospitals we have, we were not able to do a better job in providing the simplest and most cost-effective medical intervention available to us. Shortly after we released the report, I had the opportunity to review immunization performance throughout the Americas. I was dumbfounded to discover that measles vaccination levels were lower in Bolivia and in Haiti than in the U.S. Rates in all other countries were higher and most were substantially higher. As we sought to determine why the U.S. was doing so poorly, we began with the presumption that it was lack of money. But as we were to discover, there were more important reasons -- inconvenient hours for vaccination, lack of outreach to minority groups, inconvenient locations, long waiting periods in dingy clinics, the necessity of making appointments far in advance, of not

checking immunization records when children came for other reasons, etc., etc. It was a dreary story. When we had finished we wondered if more money would make any significant difference. We wondered whether the situation might not be akin to a transitional status in parts of eastern Europe in which the addition of even tens of millions of dollars could simply be lost somewhere in the system without making a difference. The Department of Health and Human Services is now trying, with a series of programs, to foster a more user-friendly system, to bring together programs at one site and to reach out into the community. The bottom line, however, is that there is a lot to be done and, even without added resources, much which we could do that we are not doing.

Personally, I am optimistic about the future. Change is possible and there is now, as never before, recognition that major changes are inevitable. There are pressures on the part of industry and on the part of consumers, there is apprehension in the academic health centers, there is concern among medical professionals and there is an insurance industry in turmoil. Now is the time to act, to begin to make necessary changes because the climate is more receptive than it has ever been. There are ample models for success in many other fields. It is clear we have gaps in mortality and morbidity between different racial and ethnic groups. This is only symptomatic of a broader set of problems including a failure to deliver health care as we should. The single unifying element as we look at the issues, be they in the field of health or social justice, is that they are not problems that can be solved alone by a city administration, a

county or state government, or the Federal government. Community action is required in which all the players unite to address the problems.

If we can successfully deal with health issues, we will identify mechanisms to solve other problems. Health is only an entering wedge, albeit an important one. It is potentially a unifying wedge. As we do so, we will appreciate more the rich diversity of America and Americans, and we will succeed in improving the lives of all.