DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

PUBLIC HEALTH IN HEALTH CARE REFORM - U.S.

D.A. HENDERSON, M.D., M.P.H.

Deputy Assistant Secretary
for Health and Science

World Bank

Seminar on Health Sector Reform in Latin America

Buenos Aires, Argentina

March 15, 1994

Health care reform in the U.S. is, as you know, the centerpiece of our President's domestic policy agenda. The reason is simple. The U.S. health industry has been growing and expanding at a far faster rate than any other part of our economy -- to a point where both industry and government budgets are perceived to be nearing a breaking point.

- This year we will spend $1000 million -- nearly 15% of our GDP on health;

- Costs are growing at the rate of 10-12% per year -- far in excess of inflation. Simply the increase this year would more than fund all expenditures on public health at Federal, state and local levels combined. Efforts to control budgets have so far proved unsatisfactory. By the year 2000, we could be spending 20% of our entire GDP on health -- $1 in every $5 expended for all purposes.

- Rapid advances in biotechnology, organ transplantation and genetic research offer new opportunities for more definitive and sophisticated medical interventions -- some of which will save money -- many could result in substantially greater expenditures yet.

- Our expenditures are now far more per capita than any other country but there are those in the U.S. who would assert that our health care system offers the most sophisticated medical care in the world. That may be true from some -- for those who can afford it -- but what we do know is that for the whole of the population the results are not optimal.

- Despite our expenditures on health, the U.S. ranks substantially below many other industrialized countries whether measured in terms of infant or under 5 mortality rates or longevity. And some proportion of our population each year -- perhaps 20% -- are without coverage.

- Ever since I entered medicine, more than 35 years ago, there have been repeated calls for a reform of our health care system. Approximately every 10 years, there is sufficient interest and concern to cause the health policy community to believe that a serious effort will be made at last. Each time, the clamor quiets down -- and, indeed, many of our U.S. physicians today believe that this scenario will be repeated this time.

- This time, however, they are wrong. Significant health reform will take place. I cannot tell you what its shape will be but I can assure you it will be a health system reform -- not simply a reform of method of payment for sickness care.

- In commenting on health care reform, it is important that you recognize that I will not be speaking on behalf of the Administration nor do my views necessarily represent official U.S. government policy. There is a reason for this.

  -- Since the President took office and declared that health care reform was a principal pillar of his domestic policy agenda, there has been an intensive

planning process involving large numbers in my own Department and countless task forces comprised of all manner of persons both within and outside the health care industry. This culminated, finally, in a bill (18" thick) which was submitted to the Congress. The President indicated this to be a blueprint around which many other versions might be crafted. **[BASIC PRINCIPLES slide]**

-- The debate has begun; numerous alternative approaches have been proposed by Congress and by different interest groups; and, indeed, the Administration has officially accepted a number of key changes.

-- The whole scene is changing rapidly -- so rapidly, that it has been necessary to designate specific government spokesmen to reflect current government views on various issues -- and those views change almost daily. I am <u>not</u> a designated spokesman on a day-to-day basis -- otherwise I would not be here.

-- My role was as participant in crafting the public health and prevention research components of the bill.

- My real interest goes back some 15 years -- when I was Dean at Johns Hopkins:

-- Four times a year, policy seminars: Professional groups

Pharmaceutical industry

Academic Health Centers

Industry!

-- Association of Academic Health Centers

-- Two years in the Bush Administration -- government did not want to take this on.

- Today, with leadership from the President, at last, we are seriously addressing issues too long postponed.

What will emerge -- Heaven knows!

Dr. Mazza spoke of health systems being in a teenage crisis period. This is true, I believe, for many countries. Regrettably, I believe the U.S. passed its teenage years -- its health system is now a very big undisciplined, overweight, awkward young adult which is going to be much more difficult, indeed, to make over into a mature, responsible system than it would have been had we dealt with it when it was a teenager. Many of us wish we had acted when Canada or Britain did to begin to bring order into a system. We did not. Let this serve as a lesson to you. The time is already late for all of us.

It is neither practical nor possible in the U.S. to effect radical changes in an industry which accounts for 15% of our GDP. Evolution rather than revolution is what I would predict. Nor is it easy when one has very large, well-organized, well financed groups who do not want to see change which adversely affects them. The eventual plan will have to take these into account.

Physicians (colleagues) -- salaries began rising rapidly about 15-20 years ago.

Now, certain groups are paid salaries wholly disproportionate to their training or the complexity of their task -- surgeons, radiologists, ophthalmologists, gastroenterologists.

There are too many physicians and we are producing more. Nothing in the health plan addresses this problem (number needed ___ -- calculation based on Kaiser-Permanente).

Need primary care physicians -- known this for 20 years -- now producing fewer than ever. Education bias and financial incentive -- health plan does make provision to deal with this problem.

Insurance Companies -- 15% administration costs vs. 2% administration costs with Medicare.

- Most -- do not cover preventive services
- Game -- insure only the healthiest
- This is not health insurance -- sickness insurance!

Pharmaceutical Companies -- more profit per dollar invested than any other sector of the economy. They perceive a threat to research if costs are contained. We all weep large tears.

Large Industry -- good ones now have some control and do not want to lose it.

Small Industry -- does not want to pay.

In brief, whatever system we finally adopt will be a compromise product partially satisfying all these interests. Do not expect that it will be specifically or even generally applicable to the problems you face.

The World Development Report may well be the most important document yet published on health care policy. For the first time, an effort has been made to quantify health care costs and benefits, carefully and dispassionately, and a rationale is set forth

which permits policy makers to identify cost-effective practices and to develop rational plans using objective analyses.

Over the past generation, most decisions regarding health budgets have been driven largely by physicians and planners, who understand health care to be the provision of sickness-care services-hospitals, clinics, surgeries, cat scans, MRIs, etc. In deciding budget allocations, the usual questions are whether we should train more physicians, build more hospitals or purchase more equipment. Rarely has the really important question been asked -- how best do we allocate resources to have the healthiest possible populations. Only in recent years have options other than sickness care services begun to be examined -- specifically, should greater resources be made available for vaccines, for example, or school education programs designed to prevent drug abuse or teen-age pregnancy or perhaps for improved water systems or for measures to insure a safe food supply.

When we seriously ask such questions and take action accordingly, only then are we serious about health system reform and not sickness care reform.

(**EXPAND** -- Experience 1970's -- vaccine preventable diseases)

In my own country, I regret the situation has not been significantly different than in most of yours. Over the years funds for immunization were never sufficient to provide to all in the population adequate supplies of vaccines recommended by the American Academy of Pediatrics or by our Federal Advisory Committee. This in itself was paradoxical.

Vaccination is, by far, the single most cost effective measure available of all medical procedures. At the same time, it is the simplest of medical procedures to perform. Study after study has documented clearly that for every dollar spent on immunization, we save anywhere from $5 to $15 in medical treatment and rehabilitation. And yet, until one year ago, immunization was not a priority for any U.S. President or any Administration. Fortunately, the situation has changed. Immunization is now one of the President's top domestic priorities and budgets for it have doubled and trebled.

Other public health measures are now receiving increasing attention but I would not for a moment pretend that budget allocations yet come close to reflecting what a sensible analysis would suggest.

An important reason for this is that we, as policy makers and planners, have paid little attention to what our health care dollar buys. When we invest more money in clinics and hospitals, we intrinsically believe that the outcome will be a healthier population living longer and more productive lives. But are they really healthier, more productive and long-lived? And, if so, how much improvement occurs as a result of the investment we make. In most cases we have no idea. We collect very little information on human health; much of that which is collected, is incomplete and in error; and, most important, seldom are such data utilized to make decisions. Contrast our state of knowledge with that of farmers and the agricultural sector as a whole, where production is carefully measured against the

particular seed strains used, the amount of pesticide required, the amount of fertilizer applied and the extent of irrigation.

Little more than a generation ago, medical expenditures in all countries were essentially of little consequence. In truth, curative medicine had little more than a handful of truly efficacious drugs; diagnostic measures were comparatively primitive and inexact and surgical procedures were limited in number. It is generally acknowledged that since 1900 virtually all progress in diminishing mortality and extending life occurred as a result of enhanced nutrition, better water and sewage, immunization and improved housing. Recent decades have witnessed a veritable revolution in sickness care with vast number of new drugs, a proliferation of new types of equipment for diagnosis and treatment, the development of new fields such as organ transplantation, genetic screening and radiation therapy. Expenditures for sickness care have exploded and, indeed, promise to continue to grow logarithmically. We now recognize that it is financially impossible to provide for every citizen every available medical intervention.

For the first time, we -- all countries -- are having to make choices as to what medical care we will provide but with all too little data available to guide us in making sensible, objective choices. Thus, the importance of the World Bank report as the first framework which endeavors to examine which of the activities in health are the most cost-effective. Could even better choices be made with more current and accurate data? Certainly, they could -- and this is one important message of the report. We need far better

surveillance for the indicators of health and disease -- better data as to what is needed and what works and what does not, and what it costs.

A second message is that we could usefully spend far more money on public health measures designed to prevent disease instead of added resources for treating disease after it occurs.

The IOM/NAS published a study in 1982 which analyzed the relative importance of different major interventions in reducing rates of premature death. **[PREMATURE DEATH slide]**

In designing the Clinton health proposal, this was certainly uppermost in our own minds and this resulted in the development of a special component of the plan called the "public health package."

But let us look first at the history of health expenditures in the U.S. over the past decade. **[EXPENDITURES in US slide]** Several points need to be made:

1. Tripling of health expenditures over a 12 year period:
   - For 1994, they will exceed one thousand million dollars;
   - Represents 15% of our G.D.P.

2. Public health expenditures have grown as well:

- Slower rate of growth;
- Lower proportionate expenditure of total health care costs;
- Less than 1%.

The President's plan identifies a number of functions specifically to be core public health activities. **[CORE FUNCTION slide]**

A special Task Force was constituted which included professional staff from across government and included state and local health officials as well as those from the university community. They were asked to develop two cost estimates -- first, the minimum amount required to meet essential public health needs and, second, an estimate to cover fully all needs. It was determined that approximately twice as much would be needed to meet essential needs but that an optimal figure could be about $25 billion or approximately three times our present expenditures. Note, however, that this would still represent only 3% of the total health care bill. For the health plan submitted to Congress, the lower figure was selected, recognizing the difficulties in wisely spending when budgets accelerate too rapidly.

A further challenge, as we saw it, was to invest more substantially in research designed specifically to improve preventive measures available to us. Our past NIH research agenda has substantially reflected the interests of those most concerned with

sickness care. Over the past decade, research in preventive measures has received increasing support but far from enough. Accordingly, we crafted a basic research package calling for an additional $500 million per year with the goal in mind of new and improved vaccines, better contraceptives, a better understanding of and methods to deal with micronutrient deficiencies, congenital malfunctions, substance abuse and exposures to toxic substances. This, too, is in the plan.

I wish I could tell you that the logic of our decisions and the plan were enthusiastically welcomed and unanimously adopted. It was not. Certain of our economic geniuses had a most difficult time trying to understand why money was needed for public health if we were providing sickness care for the whole of the population. It took no end of persuasion, graphs, diagrams and explanations to get them to understand that sickness care was only a part -- indeed, in terms of the population's health, the smaller contribution to better health of the population.

My concluding message to you is at this time, "look to Canada, look to Europe" in devising your own health systems and consider with care the message of the World Development Report. We are.

PRESIDENT'S SIX PRINCIPLES OF HEALTH CARE REFORM

1. **Security** – Comprehensive benefits for total population

2. **Simplicity** -- One standard claims form
   Computerization of records

3. **Savings** -- Competitive pricing through large purchasing pools

4. **Choice** -- Option of at least three plans

5. **Quality** -- Monitoring system for assurance of quality

6. **Responsibility** -- Patients; physicians; laboratories; lawyers

Source: Budget of the United States, 1995

AVOIDANCE OF PREMATURE DEATH

Improved access to medical treatment	10%
Changes in behavior -- smoking, drugs, injury	50%
Environmental factors	20%
Congenital defects	20%

Source: Institute of Medicine (NAS), 1982.

U.S. EXPENDITURES ON HEALTH (billions)

	1981	1985	1989	1993
All Health Expenditures	$290.2	$422.6	$604.3	$900.0
Public Health Expenditures	3.5	4.1	5.7	8.4
Public Health - % of Total	1.2	1.0	1.0	0.9

Source: Public Health Service

CORE PUBLIC HEALTH FUNCTIONS: POPULATION-WIDE SERVICES

Health status monitoring and disease surveillance

Investigation and control of diseases and injuries

Protection of environment, workplaces, housing, food, and water

Laboratory services to support disease control and environmental protection

Services for special programs -- immunization, family planning, substance abuse, AIDS

Health information; social marketing

Community mobilization for health-related issues

Targeted outreach and linkage to personal services

Health services quality assurance and accountability