The American health care system
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As the introduction implies, I have gradually become an expert in the present sense of the world - knowing more and more about less and less but there are few experts who can claim to have simultaneously reached this peak of success only to have the subject of their expertise vanish unceremoniously. Who needs a smallpox expert today? What does one do under such bizarre circumstances? Perhaps the answer is obvious - one becomes a dean - where, as I am increasingly discovering, one finds oneself knowing less and less about more and more.

I very much appreciate your invitation to participate in this seminar and consider it a special honor. I use the words "special honor" deliberately because it was all too apparent to me during the past 11 years which I spent on the international scene that the key people in the program for which I was responsible - the ones who could and did make a difference - were not those at national and international levels but those more directly on the "firing line". Whatever we did or tried to do in the international political arena, whatever we generated in research studies, whatever may have been said or done in the never-ending round of national and international meetings - all of this mattered for nought if this did not translate into something meaningful,

as we termed it, at the furthest end of the pipeline. The lesson we learned and relearned was that this translation depended specifically on capable, imaginative people on the firing line - able, willing and motivated to innovate, to implement, to decide, to act boldly - able to translate philosophy and concepts into specifics and to make it work. It didn't take too long for me to appreciate that participation in meetings with those on the "firing line" was infinitely more productive than the all too numerous meetings with international experts in esoteric forums. More than this, it was all too apparent that the inherent, practical wisdom which emerged in the course of "doing" - rather than the plans and philosophy emerging from sterile, isolated think tanks - contributed far more significantly to the program. The program itself evolved constantly - no 2 programs same - one country year-to-year - new ideas - one from Geneva. Besides, the parties the field staff threw were considerably more casual, more irreverent and a helluva lot more fun. It is for me a pleasure to be back among a group similarly on the firing line and a group to which I find it easiest to relate.

Being in the field so much myself - in fact more than 2/3 or the time, meant that I spent no more than one week per year in the USA over the past ten years. The net result is that I return to America a stranger, an international citizen of a decade's residence looking at America through different eyes than those of ten years ago. Now, for just two years, I have had the opportunity to view from the inside what has to be the world's strangest, most confused health care system in a country so

very different from any outside of North America as to defy description. To pretend that I understand this incredible patchwork of confusion or that I can propose clear directions which might bring order out of chaos would be presumptuous. I don't, but I am now consoled by the fact that no one else grasps the system either.

To a native, it is difficult to appreciate the incredible opulence which characterizes this country. As a tourist, you may assume there are shades of difference between here and Europe and undoubtedly greater contrasts between this country and those of the developing world. But the average American tourist does not travel far from hotels, eating establishments and tourist attractions which are highly oriented to American tastes. The average resident of the area has a vastly different sort of life than that suggested by the Oberoi in Delhi, the Intercontinental in Dacca or even the President in Geneva. The array of electric gadgets, enormous refrigerators, the proportion of air-conditioned cars even in such as New England are mind-boggling.

What has all of this to do with "Health Care" now or in the future? It seems to have a great deal to do with it. Hospital "X" has wall-to-wall carpeting with color TV in semi-private rooms and a cardiac catherization unit; Hospital "Y" competes by adding oriental carpets, remote control TV, private rooms and a CAT scanner. If there be a genetic defect in blond-haired, green-eyed Asiatics, why not spend a few million on a special screening and treatment program which overlaps and partially duplicates 14 other screening and treatment programs? Money

and more electronic circuitry provide a warm womb-like external appearance that one is really doing something about a problem. After all, this is the most advanced civilization the world has ever known - where else can one part with a small sample of blood and find out everything from what's right or wrong with one's electrolytes, to the state of one's liver, to whether it's time to see one's hair dresser? Prolifigate duplication, material extravangances and a euphemistically called "pluralistic health system" are intrinsic components of this culture.

But also part of the culture is the fact that the systems and approaches in this country contrasted to others are capable of incredibly rapid change in the shortest imaginable period of time. I submit that no other country, no other culture is capable of change which we take for granted in this country. The transition in attitude and policy in regard to the practice of abortion almost defy understanding. How long ago was it that abortion was an illegal procedure? Within a matter of a few years, not only was it legal but endorsed by public statement and supported by public funds? Again, almost within months, it was suddenly so politically unpopular in certain circles as to rescind federal support as well as state funds in most areas.

Opulence and capacity for change are two remarkable characteristics of this country - and its health system - but there is a third. There seems to be an all pervasive view that by careful study of a problem, a few dozen committee meetings, the elaboration of a few computer models,

a bit of highly sophisticated legislation, funds and programs can be designed to set it all right. There is an intrinsic, almost religious, faith that the single magic bullet - whether drug or legislation - can be found. The fact that one significant change in system "x" has a domino effect on 27 other systems, all likewise carefully considered and specifically crafted, is only vaguely comprehended but, if comprehended, assumed to be able to be corrected by a few more computer runs, several additional task forces, 200 additional positions and a few million additional dollars. The arrogance of the belief that a few studies, a bit of legislative tinkering and a few million highly targetted funds can mend any defect astounds the foreigner.

One senses, however, that perhaps we are on the threshold of change. There is increasing uncertainty that expanding wealth and expanding consumption are immutable economic principles of the American system. For the first time in history, there are those who are questioning how much we can afford to or should pay for health and sickness care. Less perceptible and still cautiously voiced are concerns that perhaps the sweeping nationwide, federally-mandated panaceas may not be so effective - that one approach in Appalachia may prove ineffective or even counterproductive in New York City or Harrisburg. It was obvious to everyone that to try to apply identical smallpox programs in rain forest areas of tropical Africa and to street dwellers in Calcutta was preposterous. But this is what we in the U.S. have been and still are doing in a vast range of health programs.

There is light at the end of the tunnel. Expenditures for medical services this year will approach $200 billion, nearly a three-fold increase since 1970. Mr. Califano tells us that health insurance expenses alone added $120 to the cost of a Ford automobile last year. There is every reason to believe that expenditures could more than triple again by 1984. This would be all the more certain with a Comprehensive National Health Insurance scheme. It is estimated by HEW that, still, 24 million Americans are not covered by health insurance of any kind and another 20 million have what is considered inadequate coverage. I'll simply pass over the compounding effects of an aging population which can only aggravate the problem. Additional physicians are coming to the rescue - the number is growing at a rate which is three times faster than the population. In 1966, we had one physician for every 640 persons; by 1976, one for every 515; and by 1984, we will have one for every 450. An elegant paper recently published confidently forecasts by 1984 a decrease in physicians' fees in response to the classic laws of supply and demand. One need only look at those areas which have already reached 1984 physician/population ratios to appreciate that fees and salaries in those areas are higher yet - not lower. With all of this, life expectancy rates in the U.S. are below many of those in Europe. A curious aberration is the fact that the life expectancy of an infant born in Washington, D.C., today is less than that of an infant born in Sri Lanka (formerly Caylon). It is apparent that the word "prevention" is being discussed and embroidered as if it were a newly discovered concept. Mr. Carter asserted prevention to be a priority concern and the administration subsequently reacted boldly and cut funds for training in prevention and public health.

These developments I find heartening - the situation has become acute and would seem to be deteriorating at a logarythmic rate. Rapidly approaching is crisis. Interestingly, the Chinese ideograph for "crisis" embodies two concepts - "danger" and "opportunity". Without "crisis", the opportunities for significant change are limited - today, the opportunity for meaningful change is present - the impetus for change is increasing.

More and more frequently, what one hears from key people in Washington is the belief that perhaps the only real hope for rationalizing this non-system lies with those at local levels. There is a glimmering recognition that Aroostock County, Maine, may have differing characteristics, differing health care systems, perhaps even different social and economic characteristics than, say Reno, Nevada or Harrisburg. There is even the thought that there might be some local expertise and native wisdom which, given the opportunity, might succeed where nationally mandated schemes would fail. Most of this still is talk but those who are talking are at pivotal points.

There are today such a tangle of programs, such a plethora of problems, such a spate of computers, so many economists, so many beliefs as to what should or could be done, that I doubt there are any today who really can weigh or even grasp the complex of variables. It seems all too obvious that there is no single "magic bullet" nor any single all-encompassing piece of national legislation which will transform all of this with some magic wand.

But gazing into my well-known but often-cloudy crystal ball, I would venture to predict that by 1990, as little as 10 years from now, this wonderously adaptable country could be well along toward resolution of what is patently imminent crisis and that the major actors in resolving this crisis could be those of you on the front-line in state and local health agencies and we in the Schools of Public Health.

Is this a statement born of the optimistic temperament necessary to maintain one's sanity in today's health bureaucracy or is it rational? I submit it is eminently rational. Stand aside from the problem for a monent - we have available and are spending now substantially more in real dollars for health than any country on earth; trained, educated staff are available, perhaps not in adequate quantity - nor perhaps properly educated - in virtually every technical discipline pertinent to public health and medical care; there is a tradition and practice of in voluntary organizations in this country which one simply does not find in other countries; and there is in this country a unique talent for organization - both the business community and the agricultural industry have demonstrated this. Comparable concepts of management, marketing and merchandising have scarcely penetrated the health industry for perhaps several reasons - the absence of any real economic incentive to do so. This is now changing. Second, the possibility of a consumer group which does not and cannot so dispassionately view its own health as simply another commodity. Better education is to some degree demythologizing medicine, thus permitting more rational judgment. And, finally, the dominance of the system by the clinicians. But this is

weakening. This is not to criticize all of us docs as evil creatures - I can't afford that, but our traditional medical training is counterproductive to the development of managers and management systems. Intrinsic to management is the concept of achieving goals by working through people, of delegation of responsibility, of helping others to assume greater responsibility. Medical training is still explicitly focused on techniques for the individual physician himself to diagnose, to counsel, to treat each patient one by one. To make a physician a good manager, one must begin not at "0" but at "-10". It is not easy and we haven't done well so far.

My hope, my optimism lies in the belief that the cornucopia of programs and money now pouring into health systems can be managed, that the many separate initiatives can be rationalized, priorities established and sensible directions set.

A far more responsive and economical "sickness-care" system is now at the top of the agenda but ascending rapidly is the concept that perhaps, in the longer-term, more substantial efforts directed toward prevention could be important. Who is to do this? Obviously, many groups can and should play a role but, personally, I see the state and local health departments as the potential and essential central leaders and coordinators. However imperfect this structure may appear to you, I personally am impressed by the quality of state and local health staff I have met, a staff with a depth and competence vastly superior to that which I knew only 10 years ago. Herein, it seems to me lies the future

in better, more economical health care. The solutions, the approaches to resolving the problems must inevitably be complex, unique to each area, but there is every reason to believe that the talent in elaborating the principles can be found or developed.

What needs to be done? I would suggest we stand aside from the immediacy of the teaming, confused milieu of the system and view it in aggregate. Permit me a few broad brush strokes and generalizations which if too rigorously examined may be outrageous but hopefully are provocative.

Health care, I would divide into two components - the "sickness care systems" which deal with sick patients seeking relief or cure and the "preventive system" which is meant to impact on people who are well. The sickness care systems are now comparable to turn-of-the-century grocery stores - small units, inefficiently run, with merchandise poorly labeled and a grocer who deals one by one with each of his clients, lifting each can and box off the shelf, packaging - even delivering the merchandise - and charging each one a sufficient differential to enable him to make a living. There are many today who nostalgically remember the corner grocery but, lest we forget, it was the consumer who patronized the chain supermarkets and enabled them to grow at the expense of the corner grocery. Admittedly, the supermarkets could not offer the same personal attention but lower costs made them far more attractive. Could the HMO's be tomorrow's sickness care supermarket? I believe they could but, to date, the management more closely resembles

that of a corner grocer who has acquired three corner groceries. The merchandising has little changed. To consider another pattern, fast food chains have burgeoned with attractive, welcoming decor and an assurance that service will be fast and an acceptable number of calories delivered. A three star French chef is not on the premises and the menu clearly indicates that he is not. But if you really want a good cordon bleu dinner, one goes elsewhere. Need I contrast this to the average outpatient clinic or physician's office? A fundamental reexamination of what precisely we need in sickness care, who should provide it, how it should be organized and how it should be marketed and merchandised is on the horizon. The economics are dictating this. Should we not begin to examine practical working models? If we as health professionals do not take the lead in evolving new systems, the feds will mandate it for us.

Prevention represents the second component of health care and one in which we in public health are or should be directly involved either on the delivery side or in assuring delivery. It is commonly held wisdom that prevention and sickness care can and should be delivered by one and the same group. But can it? Back in 1972, I was in the field in Iran - then in the throes of a major smallpox epidemic - and we visited West Azer baijan which had a model primary health care system - the pride of the World Health Organization. I inquired of the physician in charge as to how they could assure that each individual coming into the clinic was vaccinated. "Vaccinated?" - he said - "we don't have time for that - we have too many sick people to take care of". Primitive - a developing country - what can you expect? Recently a study in Colorado of children

regularly visiting a group of qualified pediatricians showed that only 40% received the full complement of vaccinations recommended by the American Academy of Pediatrics. Beulah Cypross in the January 1979 American Journal of Public Health reports on the frequency with which blood pressure measurements were taken during visits by patients to ambulatory care settings. Among those 45 years of age and over, surgeons measured blood pressures only about 25% of the time; internists did so on about two-thirds of the visits. As simple as the procedure and as well accepted it is that hypertension control is an effective preventive measure, blood pressure measurements in the sickness care setting are as casually disregarded as was smallpox vaccination during a smallpox epidemic. It is an axiom that sickness-care drives out prevention and that prevention is far too important to be left to the sickness-care provider. It requires a different sort of merchandising and marketing.

There are those who would argue that the "quick fix" for all of this is a national health service. I would reluctantly subscribe to this only if all else fails. Governments have not compiled an enviable record in operating efficient, responsive, imaginative cost-effective personal service industries. I can't believe that the U.S. government would do better in operating the health-care industry than it has done in operating the General Services Administration or the V.A. hospitals - to mention two of its more notorious accomplishments.

Methods must be found within some sort of umbrella structure to encourage new approaches in marketing and merchandising both prevention and sickness care which addresses the problems not of individuals but of populations. A considerably expanded management training program in health is a sine qua non; we have a great deal to learn from business but we need to have individuals with backgrounds in health and management if rational options are really to be discovered; models need to be fostered and evaluated; and the results continuously appraised in each area as to the relevance of the approach in that area.

Mechanisms for accomplishing this are not now in place but one wonders if perhaps there may not be an applicable model in agriculture which bears study. Almost 90 years ago, the Hatch Act was passed establishing the land-grant colleges. The colleges have worked in concert with federal and state agencies and through agricultural extension agents, with cooperatives and individual farmers. Research, educational programs and demonstration projects have specifically addressed the problems of the individual areas. The result has been an agricultural industry which far surpasses that of any other country in efficiency and in productivity. At the same time, it has remained a private industry - admittedly subsidized in various ways but to a negligible extent contrasted to such as western Europe or Japan. What might have happened had we federalized this industry may perhaps be reflected in the problems of the Socialist countries.

The Schools of Public Health were once intimately involved with the real world which you face and coincidently or perhaps not so coincidently at a time when public health was making its most dramatic advances. During the past 20 years most have increasingly retreated behind their walls and some have even raised the draw bridge. Research, not involvement, in the problems at the state or local level has preempted vitality. In one state, in fact, the Commissioner of Health avowed to the legislature that the School was irrelevant to the State's problems. It is, to me, analogous to a Department of Medicine in a medical school closing its medical wards on the grounds that the Department's concern is with "research and teaching" and not "service".

It is this background against which at Johns Hopkins we have reexamined our mission and direction and concluded that we must return to the bedside - to be more directly concerned especially with agencies at state and local levels in the development of health policy, effective cost-efficient systems and programs and in a continuing educational process relevant to the needs of those responsible for conducting and delivering both sickness care and preventive services. The problems of the community and research whether in the field or at the bench must be interrelated.

America's capacity for innovation and change is proven. In the health industry we have lagged far behind in major part, I feel, because we have failed to incorprate principles of modern management, marketing and merchandising in our delivery system. This, we need to rectify - if the

faculty and students of the Schools of Public Health will venture forth from their ivy-covered fortresses and if the surrounding populace doesn't annihilate them from ambush, I believe the impossible problems we see on every side will become increasingly soluble.