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Future Directions in International Health

It is a pleasure for me to return yet again to this historic, culturally rich and wonderously diverse country which I have come to love so much (and to visit again the IIHMR which is growing so vigorously). I had anticipated being here in January and I do apologize for having had to postpone that visit and for the inconvenience which that created. The fault actually rests with General-Secretary Gorbachev (and President Reagan). The story begins in December when I had been asked by the President of our National Academy of Sciences to accompany him to Moscow to work out an agreement between our two Academies of Science. Moscow in December is rather cold – and rather miserable – but the reasons for going seemed compelling and I agreed. Suddenly the General Secretary and our President decided to meet at a summit which brought to the United States most of those we planned to see. I was delighted. A trip to Moscow would be wholly unnecessary. ~~But it was not to be.~~ For reasons, I never understood, it was decided that we had to conduct our negotiations in Moscow and suggested March or April. The President of the Academy insisted on January – a month whose weather is even worse than December! And so, I spent part of January in Moscow discussing agreements with the same people we had hosted in Washington one month before. Whatever, the agreements are signed and just before coming, I finalized arrangements for the third group of Russian scientists to visit Johns Hopkins – approximately 3 times as many as we have entertained in the whole of the past 5 years. If it means, however, that we will begin to spend 1/3 as much on armaments and 3 times as much on health, it was certainly worth the trip.

As I return to India, I am especially pleased to learn of the very rapid development of activities at the Indian Institute for Health Management Research. You may be surprised to learn that it parallels

~~In the many countries~~ There is an interest, as never before, in reexamining and redesigning our health system — what we do, how we pay for it and how we manage it.

The interest in and development of our own activities in this field. What seems all too apparent is that in many countries today we are spending more, ~~There is a policy that our health~~, year more, on our health services but at the same time, policy worse. It almost seems as though we were ~~the second best~~ losing ground rather than making progress in achieving better health. In fact, this is not really true because ~~the~~ most ~~many~~ countries, longevity has increased / infant mortality rates have declined / and many other indicators show progress. The real problem is that ~~health budgets~~ government allocations for health are not increasing — and in some cases decreasing — that ~~the health budgets~~ government expenditures now are large and it is difficult ~~terribly~~ to see how they can be increased significantly. The question is regularly asked of us — as I'm sure it is asked of you — what can we do to have a healthier population — albeit without spending very much ~~many~~ more money. There are the questions for management and health economists but regrettably, ~~there~~ people with such expertise are all too few in number and the problems are large and complex.

In our country, as we have looked to the future, I have found it helpful to recall the past and I should like to do so briefly with you.

~~As we look to future directions in public health, it is necessary that we recall our history in order to better understand the future~~. In the United States none can deny but that the period extending from ~~the late 1800s~~ about 1900 through perhaps 1940-1950 was an extraordinary period in the improvement of health of populations throughout North America. One observer ~~Bill Foege has~~ translated this into very understandable ~~comprehensible~~ ~~data~~ numbers, pointing out that from the turn of the century, life expectancy increased, on average, about 15 minutes every hour. What accounted for this? As time has passed, we have tended ~~We tend~~ to forget that it was primarily community-based ~~initiatives~~ programs, ~~subsumed under the generic title of~~ which, at this time, we called public health ~~programs~~ - ~~purification~~ provision of safe water and ~~chlorination of~~ chlorination water, food and drug laws, improved nutrition with vitamin fortification of milk and ~~flour~~ wheat, the addition of iodine to salt, pasteurization of milk, immunization against diphtheria, tetanus and smallpox, maternal and child health clinics, ~~better~~ ~~sewerage~~ provision of sewers; at least in cities, and the like. Most of these changes, ~~we now take~~ for granted but at the time, each change was ~~controversial~~ debated for various reasons — including cost — and was accomplished only with difficulty. Undoubtedly, ~~an improved economy, better housing and~~ other factors ~~also~~ played a role in improving health conditions, but little is said or can be said about the contributions of traditional curative medicine - not that it wasn't needed or ~~sought~~ that people didn't seek it, only that its contributions little to better health and to longevity. ~~are~~ Even my practitioner colleagues acknowledged ~~to have been marginal, at best~~ this to have been the case. Indeed, it was sobering to me as a young medical ~~student and as a~~ resident as recently as the 1950s to realize how infrequently the medical or surgical measures available to us served to alter significantly the course of disease.

Yet this was the era when the greatest advances in health were made

Then, a biomedical revolution began and has accelerated steadily since. Among other developments, we soon had an array of ~~antimicrobial agents~~ antibiotics, more sophisticated diagnostic procedures, organ transplantation, improved surgical techniques, parenteral ~~alimentation~~ feeding and the like. For every illness, there were far more diagnostic and curative procedures which could be applied than ever before - and more often but not always to the benefit of the patient. ~~A natural and understandable constituency of~~ Understandably, a group of grateful patients grew rapidly. There was a demand for more hospital beds, more physicians to treat patients, broader and more generous insurance schemes to treat the ill. Legislators and benefactors alike responded ~~readily in~~ by providing, for example, more coronary care units and ophthalmological services from which they themselves had personally benefited. There were few indeed who expressed comparable gratitude for no longer being at risk of poliomyelitis or smallpox, for example. Thus, ~~the National Foundation for Infantile Paralysis, although promising other preventive miracles, quickly began its long slide into obscurity.~~ one in the 1970's Efforts to obtain even modest contributions to eradicate smallpox were seldom successful, however dramatic the ~~cost~~ benefits little to its cost and however ~~ratios~~.

Increasing
~~Accelerating~~ interest in ~~and support of~~ diagnostic and curative procedures was accompanied by rapidly increasing expenditures for medical care but diminishing interest in public health and diminishing recruitment to the field. My own experience reflected this. ~~I believe these experiences were not atypical of those of others~~. I graduated from a respectable medical school which, at that time, did not teach ~~taught~~ ~~neither~~ epidemiology ~~nor~~ or biostatistics or health management; the course in public health was considered to be dull, ~~stodgy~~ of no interest and more relevant to the 1930s than the 1950s. There were none on the faculty whose specialty was either public health or preventive medicine and I ~~know~~ knew of none in the class who ~~entertained any thought of these specialties as possible career options~~. considered public health as a possible career.

~~any apply who had a career interest in public health. When such applicants were encountered, there was, in fact, suspicion that they were in some way flawed or ingratiating themselves in order to be accepted. The demographics of those~~ At this time, there were few in the public health field who were ~~strangely skewed at that time. Most of the leading figures at all levels of public health were then in their late 40s or older having~~ less than 40 years old. Most had entered the field ~~during the depression days of the 1930s or~~ immediately after military service in the 1940s. Many were of excellent quality but it was difficult to identify their successors. ~~Remuneration~~ Pay was low and the status of public health was even lower and apparently sinking. Both resources and glamor were to be found in the clinical specialties and in treating patients.

Problems of recruitment into the field of public health were accompanied by diminishing numbers of articulate ~~voices~~ people to argue the cause and diminishing support for research in prevention. ~~and a diminishing level of relevance and quality in schools of public health.~~

Faculty in schools of public health, in large measure, withdrew behind their walls, forgetting that ~~they~~ the schools had originally been established ~~not as graduate training institutions but~~ as professional schools whose role ~~in part, no less than those~~ like their colleagues in medicine, was to grapple with real world problems. ~~As gradually became apparent,~~ Most faculty were unaccustomed and uncomfortable in dealing with untidy, real world programs ~~and in the rough and tumble of political policy-making~~. Few had ~~ever managed a~~ experience in managing public health program~~, and fewer still had done so recently. In truth, many demeaned those who did~~. ~~The fact that such activities were characterized patronizingly as "service activities" rather than "professional practice activities" exemplified this~~. Not surprisingly, the health services research then being conducted was often characterized as ~~"precious" and~~ "irrelevant." And indeed much was. And little or no attention was given to management. ~~Elements of this legacy are still with us~~.

In the last 5 years, however, this has begun to change.

We can all agree that what we seek is improved quality of life — less illness and less disability. But how can we do this without spending yet more money from government resources which are already very limited.

What has the past taught us? First, it has shown us that community-wide public health programs (which prevent disease) can provide far greater benefits and at lower cost than can programs which take the same amount of money and ~~put it into~~ are utilized for curative care facilities & treat people after they get sick. (Strangely,) It has been difficult for us to comprehend this simple fact. If we build a house with a good roof, we don't have to call a carpenter every time it rains. Yet, (until recently,) existing health systems, especially in the newly industrializing countries, have ignored the roof. ~~We have~~ Almost all resources have been devoted to taking care of people after they get sick. Immunization programs have been ignored; little has been done to improve water supplies; sewage systems are almost non-existent; nutrition programs are few and far between; family planning services are still very inadequate; little is being done about pollution; (malaria is becoming an increasing problem) I could go on and on.

But - you say - where do we find the money to do these things? Some of these ~~are expensive~~ (are very costly). If we can't spend more money from limited government budgets, then there is no choice but to ~~stop~~ spend less money for some things and more money for others. Most governments now devote more than 75% and some more than 90% (of their health budgets) for hospitals and curative services. If we are going to ~~proceed~~ spend more

money for prevention, then we have to spend less for curative services. Politically, this is not an easy decision. — it is not easy for a government to cut back on services which it is now regularly providing. Instinctively, we say we can't ignore people who are sick and seeking help. However, I will remind you that Ghandiji himself said "I would let the sick die if you could show me how to prevent others from becoming ill".

One of the best analyses on this subject — soon to be published — is from the World Bank called "Financing Health Services in Developing Countries: An Agenda for Reform".

- Product of many discussions — I myself gave two seminars on this subject.
- Health services divided into two categories
  - Direct curative services from which benefits to the individuals and their families are immediately obvious
  - Services which benefit society as a whole, whose benefits are high but which are not so directly obvious, e.g. water system.
- Curative services now provided free of charge or at very low cost by many governments — belief that this is where all poor must receive Rx but surveys show that in most countries - including India — 70% of curative care costs are privately purchased — and this pertains even in quite poor communities. In brief — pay for curative service — less fully for services to com. as a whole.

They offer — as an agenda for reform — 3 basic changes

(1) Charge users at govt. facilities for drugs and care. — Studies on payment in US? ? what India would show. Make provision for the very poor but charge all others. Highest charges at hospitals — studies show drift toward most elaborate hospitals. As easily Rx at health cts.

(2) Decentralize planning, budgeting and purchasing for curative progs.

Chronically underfunded — drugs, fuel, maintenance ~~/~~ cuts/ Salaries sustained
e.g. Kerosene for refrigerators / ~~etc~~ spec prog. - lots of vehicles,
not moving because of small monies for petrol or repair.

Note: Do not decentralize (so greatly) for tax-supported 'public-type' programs —
e.g. vector-control, immunization.

Management misplaced — need for training

③ Encourage more effective use of non govt. sector —
such as non profit groups, community run health plans, private practitioners.

Again — management critical — set standards and regulations, monitor performance.

Government role — in R and D.

Again — imaginative management is critical.

If these steps are taken —
Can maintain network of curative services c̄ less paid by govt.
More $ going to cost-effective public health progs.
Can fulfill Ghandi's prescription to emphasize prevention.

To do so — requires bold action, less central govt. control, more managers at the periphery.

IIHMR — right institution at right time to help in guiding this effort and in training the managers.