HEALTH CARE, 1984

Maryland Public Health Association Meeting
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You confer upon me a special honor in asking me today to present the Keynote Address at the Maryland Public Health Association Annual Meeting. 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 those 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 do the job - 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 developed in the course of "doing" - rather than the "thinking about" was of greater value to the program. Besides, the parties the field staff threw were considerably more casual, more irreverent and a helluva lot more fun. It is for me an honor and 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 of 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 little more than a year, 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 patch-work of confusion would be presumptuous. I don't but I am now consoled by the fact that no one else seems to 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 the lifestyle 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 1984? I would submit that it is more of the same. Hospital "X" has wall-to-wall carpeting with color TV in semi-private rooms; Hospital "Y" competes by adding oriental carpets, remote control TV and private rooms. 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 definitive 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 extravagances and a pluralistic health system (read non-system) are intrinsic components of a culture.

At the same time, the systems and approaches in this country viewed from afar are capable of incredibly radical change in the shortest imaginable period of time. I submit that no other country, no other culture is capable of change which you take for granted. 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 public funding despite apparent continued support as measured by public opinion poll.

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, the elaboration of a few computer models, a bit of highly sophisticated legislation, funds and programs can be designed to set it all right. 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, 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.

What has this to do with health care and the health system in 1984 or 1990? A very great deal. America's wealth, once dealt with as infinite is both definite and mortal. Even in Congress, one senses this realization is dawning gradually. Additional hundreds of Washington-designed programs to attack highly specific national problems at local levels which demand - but ignore - one solution in Arkansas and another in

Vermont are simply not in the cards. One ridicules the idea of having a smallpox program for pygmies in the Congo which is identical to the program for street dwellers in Calcutta. But this is what you in the U.S. have been and still are legislating!

But 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 automibile last year. There is every reason to believe that expenditures could more than triple again by 1984. This is all the more certain what with National Health Insurance on the horizon. 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. But 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 considerably down the scale from many of those in Europe. At the other end of the scale, it is said 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 Ceylon). At the American Public Health Association meeting this past year, it was said repeatedly that the word "prevention" was being discussed and embroidered as if it were a newly developed concept. Mr. Carter has 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 seems to be deteriorating at a logarythmic rate. Rapidly approaching is a major crisis - and with crisis comes opportunity - opportunity for truly significant change which simply is not possible without real crisis.

More and more frequently, what one hears from key staff 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, Montgomery County or Harford County or Baltimore City. 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 personally 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 serve to brake this run-away freight train.

But gazing into my well-known but often-cloudy crystal ball, I would venture to predict that by 1984, not 6 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 will be those of you on the front-line in state, local and voluntary health agencies.

Is this a statement born of a necessarily optimistic temperament so necessary to maintain one's sanity and balance in today's health bureaucracy or is it rational? I submit it is eminently rational. Stand aside from the problem for a moment - 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 - but available - in virtually every discipline relevant to public health and medical care; there is a tradition and practice of public service (free help) in this country which one simply does not find in other countries; and there is in this country a unique talent for organization. Where's the problem? I sense that the basic problem lies fundamentally in the excess of riches - the incredible number of largely uncoordinated, highly focused separate health initiatives by public and private organizations alike. My hope, my optimism lies in the belief that there are now emerging orchestrators to begin to bring the separate initiatives together - industries, unions, community groups who are demanding that some system be interjected - perhaps that Health Maintenance Organizations might have something to offer - than an accounting be rendered for the dollars spent. These questions are now being asked, often timorously - sometimes aggressively - but increasingly, meaningfully.

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 may become 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 essential central leaders and coordinators. However imperfect this structure may appear to you, I personally am impressed by the quality of staff I have met, a staff with a depth and competence vastly superior to that which I knew only 10 years ago. More than this, I am impressed by the fact that Maryland's structure is one of the strongest in the country. Herein, inevitably 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 leadership in elaborating the principles rests here in this Region.

Hopefully, we at the Johns Hopkins School of Hygiene and Public Health may abet the process. You may be surprised to know that the School of Hygiene today represents the world's largest faculty engaged in public health research, teaching and service. It has become clear to all of us at the School that we need to join much more actively with you in endeavoring to resolve these, the most significant health and medical care crises with which we as a nation have ever been faced. We must work together if what we are to do in research and teaching is to be relevant to the needs of the real world. We need you - we hope that you will need us and call on us. More than this, in the cauldron of crisis - and opportunity - the country needs us both to try to disentangle, to rationalize and to simplify an incomprehensible system with the single objective of a healthy community for us all. May the barriers which in 1978 still remain to separate us be relics of the past in 1984. We at Johns Hopkins pledge our best efforts to achieve this.