DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

CONVOCATION ADDRESS

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

Deputy Assistant Secretary
for Health and Science

University of Alabama at Birmingham
School of Public Health
Honors Convocation
Birmingham, Alabama

June 3, 1994

CONVOCATION ADDRESS

It is an honor and special privilege to participate with you today in these convocation exercises. You embark upon a career in public health at a time which promises to be for public health professionals the most exciting period in our entire history. You enter this field just as advances in biomedical research are opening whole new vistas of opportunity. You enter at a time when we have begun to appreciate the challenge and potentials of the behavioral sciences and to apply them practically. You enter the field at a time when, at last, we have begun to take health reform seriously. Symbolic of this promise is the fact that today you broke ground for a new building — and only a week ago, I attended similar ground-breaking ceremonies at the Johns Hopkins School of Hygiene and Public Health.

It is gratifying to me to see, at last, the breadth of interest in and concern for our health care system and the host of people who have begun to inform themselves about the issues and to engage actively in this debate. This is a sea change from a situation I remember all too vividly little more than two years ago when I served at the White House. It had become increasingly apparent to me from numerous discussions with patients and with the private corporate sector, that they saw the medical care (so-called) system as serving them ever more poorly. Moreover, many corporate clients had both the will and financial clout to effect change which would at least constrain their own costs — and they were beginning to do just that. It was also apparent that such changes predictably would have far reaching effects on medical care practice, on the health of the public at large and

on academic health centers in particular. I discovered, however, that most of my curative care colleagues and, indeed, the academic health centers themselves, viewed the problem with apathy and with disinterest. I proposed the possibility then of some sort of White House Committee or study group which might at least expose a broader constituency to the ever-mounting problems. However, I found little interest anywhere in such an initiative — on anyone's part. In truth, a large number expressed the view that the chains of reform had been rattled before — indeed, about once every decade — and if one simply ignored the problem, the agitators would go away.

I believe it is safe to say that this time, there will be change. It is long overdue. The Administration has orchestrated an extraordinary educational effort engaging everyone from consumers, to the medical community, to insurance companies, the pharmaceutical industry and others. I believe, it is now widely recognized that we do not have, in fact, a health care system but, rather, a dysfunctional plethora of mechanisms to pay for sickness care. I am heartened by the fact that this educational process alone has already facilitated the beginning of surprisingly extensive systemic changes. We are witnessing an expansion and proliferation of integrated systems — be they HMOs or PPOs. Academic health centers, as well as many other hospitals are consolidating and reorganizing into vertically integrated systems. Consolidated purchasing systems have grown. And the pharmaceutical industry, to deal with this new world, has begun to effect a series of mergers. In brief, even without legislation, the medical scene will never be the same again.

But certainly, health care reform legislation will emerge from Congress, although in what form is yet meaningless to speculate upon. Five different committees are each crafting their own versions. The ultimate product will inevitably be a trade-off compromise among all of them. Parenthetically, it has been said that one should not watch legislation being made any more than one should watch a butcher make sausage. That adage is especially relevant today.

The gravity of problems in our so-called health care system results from the fact that we have delayed far too long in addressing these problems and certainly far longer than most other industrial nations. We thus have precious little experience and few home-grown models to examine as we address even the most obvious issues:

1. A health system which provides access for medical care to the whole of the population.

2. Data collection systems which permit appropriate planning and resource allocation as a dynamic process.

3. Systems which permit the continuous monitoring of the health of the population as a whole and the quality of both preventive and sickness care.

4. Mechanisms which permit the fashioning and enforcement of a rational budget — a far cry from the "cost-plus" payment schemes which now pervade our system.

It would be foolish to anticipate the delivery of a full-blown, fully functional final plan either this year or even next or even 5 years from now, however well-intentioned the architects or, however extensive our economic modelling. We are, after all, talking about revamping an industry which accounts for 15% of our gross national product. Although a dysfunctional structure, it is nevertheless made up of complex, interrelated networks of service providers, payment mechanisms and suppliers involving a host of private sector institutions as well as Federal, state and local governments. Any significant change at any point in such a system inevitably results in rippling changes across the whole of the system, often with unanticipated, sometimes seriously adverse, consequences. Major changes are required but to attempt the totality of needed restructuring as a single step would be folly.

Thus, we must be prepared to engage ourselves in a process of evolutionary change extending indefinitely into the future. And who could be more relevant to that process than public health professionals and the Schools of Public Health. The disciplines most central to the process of creative change you know well — they involve measurement and concern for the health of the population as a whole - epidemiology, health economics, behavioral science, industrial health, biostatistics, health policy. That does not mean that your involvement and that of others in public health is inevitable. The right to so participate will still have to be earned through relevant involvement. That is not inevitable. I personally

recall only too well the creation some years ago of a network of health service research and development centers. Most centers chose to view themselves as detached scholars of the system, as centers for graduate study, not as participant activists. The faculty published marvelous journal articles for each other and talked to each other in all manner of professional meetings. Not surprisingly, they came to be characterized as "precious" and "irrelevant."

Public health initiatives themselves pose a special problem. They are not well appreciated or understood by policy makers outside our own field. In fact, I have been astonished by the innocence of so many of today's health plan architects with respect to public health. Regularly, the question is posed: "If health care (read sickness care) is provided to everyone, what need is there for public health services?" And, indeed, at points in the current drafting process, the public health initiative has been stricken from the package more than once--although, happily, rescued again.

How does one explain public health? We generally have not done well in our efforts. Personally, I begin by asking the question as to what are the most important disease problems today? And, so the litany — AIDS, substance abuse, mental health, tobacco, violence, teen-age pregnancy, cancer, heart disease, food poisoning and one could go on from there. What can the best and brightest of our family practitioners, internists, surgeons, radiologists do about these problems? Treat the crack addict after he is addicted, provide obstetrical care to the pregnant teen-ager, offer solace to the patient infected with

HIV, bandage up the gunshot wound in the ER, give chemotherapy to patients, many with preventable cancers or do bypass surgery for cardiac victims who might never have been hospitalized if they had followed reasonable dietary and exercise regimens. There is no question but that sickness care providers are essential but it becomes apparent as one considers the health of the population that the services they provide are often limited and far too late.

The challenge now to you as graduates and, indeed, to the entire public health community is to actively intrude yourselves into the heart of the health policy and planning exercise. During the course of my professional life, it has seemed to me that public health has too often remained peripheral to the central debates, whether in policy formulation or resource allocation. I don't believe this is inevitable or intrinsic to public health, although some believe it is. And I look to the biomedical research enterprise for inspiration. Over a period of just 40 years, we have transformed our biomedical research establishment to the point today where it is the envy of the world — an elaborate, well-integrated engine which extends from basic bench science through clinical research to medical application. As the IOM study has so thoroughly documented, public health is, in contrast, a disjointed, often unrelated, set of separate initiatives, operated by a whole variety of different institutions — underfunded, understaffed and poorly coordinated. Many academic institutions seem to be on a different planet from their own state and local health departments which, in turn, seem often to be at swords points with each other and the Federal government.

I have wondered if the history of development of our biomedical research enterprise might not have relevant lessons to public health. At the hub of our research enterprise and effectively serving as its engine is a National Institutes of Health which perceives itself and is perceived by others to be effectively an orchestrator of a national system. All manner of outside experts are regularly convened to decide on research and training programs, on appropriate clinical experimentation and its application in some 20,000 public and private institutions dispersed across the country. Nearly 90% of its budget is utilized in extramural endeavors. It measures its success in terms of the health of the national enterprise — not simply the productivity and creativity of its own scientists.

Most of the institutions to which it provides funds embrace a broad agenda of activities extending from work at the bench through its application to patients, and, indeed, research funds are supplemented by substantial revenues from such as Medicare, Medicaid, state and local funds which permit them to serve as integrated teaching, research and practice centers.

Suppose that we had a Federal institution comparable to NIH whose primary mission and measure of success was the development and performance of our national public health enterprise be it private or public institutions or state or local governments. Comparable to NIH, it could draw heavily on expertise from all relevant sectors in planning and implementing its program and, like NIH, its budget might be divided say, 90% for extramural programs and 10% for intramural.

An initiative such as this would demand, in turn, a responsiveness by academic public health centers to actively involve themselves in state and local health programs and in the process as a whole. It would, of necessity, dictate that schools of public health be professional schools rather than graduate schools, actively engaged through their teaching and research in the end product — better health throughout a population. In fact, our schools would resemble more closely Schools of Medicine than graduate education centers akin to Colleges of Arts and Sciences. Obviously, different funding arrangements from those that now exist would be required to permit this to happen. But, is such a paradigm not worth pursuing?

The bottom line, quite simply, is that our medical care system — our system for sickness care is rapidly changing and will never be the same again — and neither should public health. However, the seismic changes now beginning to roll across the medical care system have scarcely rippled the public health establishment. In fact, I have yet to hear much discussion about the significant changes that should or could be made — whether at Federal level, or in academic or in state and local health departments.

There is an opportunity before us but the time to act is now. What an exciting time to enter the professional world of public health. I salute you and wish you well.