Incidental Reflections Based on a Career in Public Health and Public Health Policy

Donald A. Henderson, M.D.

Donald ("D.A.") Henderson was born in Lakewood, Ohio, and received his Bachelor of Arts degree at Oberlin College, Ohio. Following internship and medical residency at Mary Imogene Bassett Hospital in Cooperstown, NY, and training in Public Health at Johns Hopkins School of Hygiene and Public Health, he has had a distinguished career in international public health and national health policy planning. In the 1960's and 70's he directed the WHO team that eradicated small pox from the globe and initiated WHO's world program of childhood immunization against six major diseases. As Dean of the Johns Hopkins School of Hygiene and Public Health , Associate Director of Life Sciences in the President's Office of Science and Technology, as Senior Scientific Advisor in the Department of Health and Human Services, and following 9/11/2001, as director of the program to vaccinate Americans against smallpox, he has made important contribution to public health policy in America. His essay emphasizes "preventive care" over "sickness care".

Having had a 40-year medical career with limited experience in physician-patient relationships, I concluded that it would be presumptuous of me to offer sage observations on "how contemporary changes in medical practice have affected the Patient-Physician Relationship personally experienced by the individual in his practice". Thus, I consigned the proposal to the files and decided to await enlightenment. Subsequent telephone calls from the organizers, however, were eventually persuasive in arguing the saliency of wisdom propounded even by the unqualified. "After all," they argued, "you have served as a politician in Washington and even as a Dean. Most of your career," they observed, "has been devoted to offering wise insights on subjects with which you have had no personal experience and oftentimes little expertise."

My career has been in the fields of public health, academic administration and science policy and so my views on health care policies and consequent patient-physician relationships are from a somewhat different vantage point then that of many of my classmates.

As I have viewed the medical field over the past 40 years, it seems to me that medical care and health care policies have been all but totally dominated by a curative care agenda. This is illustrated, perhaps inadvertently, in the circular letter we all received. Note that all of the cited positive developments of the past 42 years refer to curative medicine - organ transplantation; renal dialysis; treatment of hypertension, myocardial infarction and congestive heart failure; open heart surgery; new imaging and nuclear scanning devices; and the application of molecular biology to the diagnosis and treatment of disease. Not cited are two developments in the field of prevention of disease

and disability - vaccines and antibiotics -, which have resulted in the aggregate addition of more years of useful life than the sum total of all other enumerated developments! The point, quite simply, is that sickness care has been the big gorilla.

With a burgeoning cornucopia of new diagnostic and therapeutic interventions, national policy has been directed toward the provision of more hospital beds and more elaborate diagnostic instrumentation, the training of more physicians for curative care, and expanded comprehensive insurance schemes. And we do become familiar with Hill-Burton, Medicare, Medicaid, Ryan White, the War on Cancer (primarily a therapeutic war), and a rapidly increasing number of special disease programs beginning with AIDS and extending to heart, lung, kidney and liver disease, plus chronic fatigue syndrome and many more. Most such initiatives have been devoted primarily to methods for the detection, diagnosis and treatment of illness - in brief, sickness care.

My areas of concern- disease prevention and public health - compiled a quite different record. NIH made available only modest resources, often under duress, for prevention research; support for public health training programs all but vanished; health department resources steadily eroded; and surveillance systems for disease detection and documentation deteriorated to the extent that today they are generally less comprehensive and reliable than they were 30 years ago.

Meanwhile, medical care costs steadily accelerated, far outpacing inflation. Ever more urgently, especially over the past decade, private and public sector consumers have questioned what could be done to constrain health care costs. From those outside the system, the health care demands appeared to have a seemingly unquenchable, voracious appetite for ever more costly services but with few measurements or indices which provided objective accounting as to what was being purchased or at what actual cost. Not surprisingly, there was an increasing clamor for measurement and for accountability but few data were available to permit informed choices to be made.

The fact that expenditures for health (more accurately described as sickness care) rose from 5% of GNP in 1954 to 16% today is startling. No other sector of the economy has exhibited such extraordinary growth.

What have these expenditures purchased? We now agree that we have far too many hospital beds and a growing excess of specialists; but what of the health of the population? Regrettably, there are few measurements to which one can point which characterize progress in terms of the overall health of the population at large. It is repeatedly stated that we have the finest medical care system in the world, but where is the evidence? Often cited as one important indicator of progress is the gain in life expectancy from 48 years in 1900 to 76 today, a remarkable increase of 28 years or 58%. However, all but 7 years of that increase occurred before 1950 and is attributable primarily to public health measures, better water, better housing and better nutrition. Since 1950, life expectancy has increased by just 10%.

Since most of the expenditures for sickness care are incurred by those over 60 years of age, might we not expect to see significant, perhaps dramatic changes in longevity among seniors? Unfortunately, the data are not especially impressive. In 1900, a 60-year-old could expect to live to age 75; in 1950, to age 77; and now, to age 81.

In passing, it is pertinent to note that longevity figures for the United Kingdom (and its much maligned health system) are indistinguishable from those in the U.S., albeit sickness care expenditures in the UK have remained at levels less than half of those in the U.S.

These data do not, of themselves, make a very persuasive case either for the wisdom of the investments which have been made or for the assignment of substantial additional resources for medical care. Conceivably, measurements documenting a population-wide improvement in "quality of life" might be more persuasive, but such data are sparse and the measurement methodology of uncertain validity.

Meanwhile, other observations have emerged which are likewise disquieting. Wennberg's studies showing variation from one area to another of 10 to 30-fold and more in the frequency of performance of certain surgical procedures such as hysterectomies, prostatectomies and hernia repairs suggest either the performance of a great many unneeded surgical procedures or perhaps a gross underutilization of medical care. Whichever the case, it would seem that some sort of approach to the ongoing monitoring of the broader need and legitimacy for such surgical interventions would be warranted as a quality assurance mechanism, but I am unaware of any such scheme having been implemented. Another disquieting occurrence was the sudden resurgence of measles in 1989-90. In investigation, it was found that the principal cause was the failure on the part of practitioners to regularly vaccinate children when they were brought to clinics either for well-child checkup or because of minor illness. This was surprising given the well-recognized fact that immunization is, by far, the simplest, most cost-beneficial of all procedures in medicine. However, a wider exploration of pediatric practice revealed that many pediatricians were remarkably cavalier about vaccination. Typifying this attitude was the fact that relatively few sent reminder notices to parents as to when vaccinations were due. (I contrast this with the practice of my veterinarian and my Jiffy-lube operator who are diligent in sending reminders as to when my cat needs vaccine and my car needs an oil change.) Astonishingly, as recently as 1992, two of the nation's best HMOs, each with fully computerized records, reported that they had no information as to their performance in assuring that the children under their care were fully vaccinated. When they did analyze the data, they discovered that coverage was only 75%.

It seems to me that society over the years has exhibited a remarkable forbearance toward our medical care enterprise with respect to accountability. It has paid what was asked (usual and customary fees), provided support on demand for residency training and required neither quality assurance measures nor an accounting of the costs and benefits of the services provided. Is there any profession, other than perhaps law, which has been so insulated from public accountability and debate as to the wisdom of the investments being made?

Thus, I find it difficult to imagine a future for medicine unless it is characterized by the words "measurements", "management", "accountability" and "cost-benefit". Compared to other sectors of the economy, these are words and concepts which, if anything, are long overdue. Properly incorporated into the practice of medicine, I would suggest that, rather than activities to be feared, they could in the long term improve greatly the practice of medicine and serve to effect a more appropriate allocation of resources and personnel. This would happen, however, only if those broadly concerned with health - providers both of curative care and preventive medicine/public health - were to join forces to deal proactively with the challenges now so clearly before us. Regrettably, I continue to hear wistful nostalgia for a past that cannot be, aversion to taking part in a now rapidly evolving agenda, and open hostility to the inevitabilities in an industry which is reshaping itself just as other industries have been forced to do over recent years.

In the evolving new world of medicine, it seems to me that the assurance of a satisfactory patient-physician relationship is paramount. Might relationship not be more productive if it incorporated stronger motivations for physicians to be more greatly concerned about continuity in the care and maintenance of health in their patients, about patient satisfaction and confidence in the physician, and about measurements and the assurance of quality? The first two of these concepts remind us of values embodied in the old family practitioner and the last echoes our belief in medicine being, at least in part, a science. A patient-physician relationship based on these premises ought to prove more rewarding than most such encounters today.