Hard Choices in Public Health

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THE THEME OF THIS PAPER is some hard choices that public health must face as it enters the 1990s. Although these may be controversial to some, they are raised to stimulate thinking and not just to create more controversy.

One of the hard choices that must be made is the delineation of the responsibilities of public health. Over the past 20 to 30 years, many issues have been gathered unto the generous bosom of health. For example, consider homicide, homelessness, child neglect, and a host of others that we have chosen to address as health problems. Clearly, every one of these involves poor health consequences or poor health as a contributing factor. Furthermore, there should be no concern about their being addressed, but one worry is that they are rapidly becoming primarily health problems.

Does the public health apparatus of this country have the competence to address them? There is no question but that public health must be involved in society's exploration of solutions to the problems of the homeless. Many of these people are on the streets because of their health problems. Yet, I wonder whether we are prepared to undertake the responsibility for the total solution. Can we bring in enough people with expertise in housing, job training, and all of the other factors necessary to find a total solution to the plight of the homeless?

Can the limits of our competence and responsibility be defined? Those limits cannot be drawn rigidly—they must be somewhat fuzzy, but there must not be a situation where the lines do not even exist. If the responsibilities of public health become so broad as to include many of these issues, then it is necessary to alter the curriculum, the selection of students, the evaluation of students, and other factors so that graduates have the competence to address them. If not, educators are not doing their job. If, on the other hand, certain responsibilities are not accepted as primarily those of public health, then we must say this. We need to convince policymakers that our abilities are limited. Is there a solution? In any event, it will be gradual in coming irrespective of the answer. It will not be a revolution but an evolution of ideas and concepts and, indeed, continuing debate.

Setting Public Health Priorities

A second and related issue is that of priorities, and this issue has two aspects. The first of these has to do with process. How are priorities for public health to be set? My observation is that priorities now are being set largely by the vector sum of forces operating on decision-makers, leading more and more into a "disease-a-month" approach to public health. Furthermore, the media are playing a larger and larger role in setting public health priorities. Programs on television or editorials in newspapers can increase dramatically the pressure on elected officials so that resources are re-allocated in ways that may not be scientifically feasible or that lead to a distortion of efforts. Indeed, many people in public health are using the media to put greater priority on their area of interest. This is accomplished largely by increasing the fear of the populace.

Further, increasing attention is being put on the lobbying of State legislators and the Congress; again, to shift priorities. Lobbying for health organizations, including universities, in State capitals and in Washington has become big business. How rational is this whole process? How sensitive is it to scientific feasibility, to the full definition of options, even to making use of our best knowledge?

For evidence, one only need examine changes in the budget of the National Institutes of Health (NIH) over the past 20 years. It is important to

emphasize that money is only one way to measure the importance of public health problems. Yet, to the extent that congressional and legislative actions represent the will of the public, it is a good indication of the priorities. What one finds is increasing earmarking of the NIH budget. Indeed, according to NIH data, more than 25 percent of the NIH appropriation is now earmarked for specific problems. This allocation virtually eliminates the legislated role of the advisory councils of the NIH to set health priorities. Furthermore, there are changes in the organization of the NIH to include new institutes and the re-naming of others. There seems to be a belief that if you are working with a problem and can get an institute devoted to it, or at least have it named in the title of an institute, then the resources for it will be increased. The evidence is not consistent with that belief, but it nevertheless persists. When reallocations are made, investigators try to make their research activities fall within this new priority system, or leave an important area of research to pursue another because it is "popular." Or, if convinced that your fundamental area is important—and who will admit that they work on unimportant problems—a media and legislative campaign is started to get that problem declared a high priority. Note that few, if any, of these actions provide for the kind of debate and thoughtful consideration by the health community to arrive at a priority system or goals to be achieved.

One of my concerns about acquired immune deficiency syndrome (AIDS) is that it is beginning to attract so much attention that other things are being neglected, or at least receive less emphasis. AIDS must not be minimized. It is a vital problem, it is one that demands our best efforts, and it is one that must be solved. However, recognize that as of now there have been less than 30,000 deaths in the 6 1/2 years of this epidemic. In that same period, more than 150,000 people have died because of drunk drivers in the United States, and nearly a million have been injured. Yet, little emphasis is being put upon this serious problem because there is just not enough time on TV or enough space in the newspapers and magazines to continue the kind of attention that is needed. There are groups calling for mandatory testing for the presence of antibodies to human immune deficiency virus (HIV) and, yet, there are no calls for some mechanism to insure that alcohol abusers are denied a driver's license. At the same time, AIDS has re-focused attention on a very important problem, drug abuse. That is an important byproduct, but even here, comments are made to focus attention on needle sharers because that is the way AIDS is spread and that a lot less attention can be paid to the IV drug abuser who doesn't share needles.

Many of the health problems being addressed today, including drunk driving, alcoholism, drug abuse, and others, require work with law enforcement agencies. It is necessary that we separate our responsibilities from theirs, or there will be conflict between the health community and the law enforcement apparatus. We must work together—and work together effectively—recognizing that the methods will not always be the same.

Importance of Incremental Goals

A third and related problem is the ability to define public health goals. The concern is not about the ultimate goal but rather the incremental ones. Again, turning to AIDS as an example, can some specific goals be defined for intravenous drug abuse? What are we really trying to do—reduce the transmission of HIV or get drug abusers off of heroin? Only if the goals can be defined will it be possible to define methods for achieving them. If the goal is to reduce transmission of HIV, then methods such as educational programs aimed at the use of clean needles, the supplying of clean needles, and related measures must be considered. But, if the objective is to cure people of their addiction, then other methodologies must be used. What are the goals? There does not seem to be agreement.

Some Pitfalls of Cost Containment

A fourth problem is consistency. Consider this example. Since the early 1970s, attention has been focussed on cost containment. The objective is to reduce the per unit cost of health care services. What is fascinating is that the savings are typically evaluated by looking at the total cost which ignores the effort to bring additional people into the health care system and the delivery of new services. Many steps have been taken to try to achieve the goal of cost containment.

At the same time, there is concern about the education of health professionals. The charge is that the health professionals now being graduated are not sensitive to the patient's total needs, that is, they are technologically competent but very narrowly trained and unable to deal effectively

with people or to provide comprehensive health care. Antecdotal and other information is put forth to support that charge. I consider it very desirable to revise our educational methods so that health professionals will be capable of delivering high quality, caring, and compassionate health care; but we are approaching a dramatic conflict between two objectives.

For example, cost containment measures include reduction in the length of stay of patients in the hospital. Therefore, in many teaching hospitals today, a medical student is very likely to see a patient for the first time on the operating table. Patients admitted for uncomplicated gallstones will frequently enter the hospital at 6:30 or 7 a.m. and undergo surgery at 7:30 or 8 a.m. that same morning. Furthermore, they will often go home with their stitches still intact.

It is difficult to understand how we will be able to teach students how to approach patients comprehensibly when the students know more about the patients' gallbladder than they know about their lives and, therefore, other health risks that they may be encountering. If most of the conversations and interactions between the student and the patient occur during the post-operative period when control of pain and fluid replacement, nutrition, and so forth are the predominant concerns, what will be the result? It is likely that the result will be a technologically competent physician with no understanding of the patient's exposure to health risks, stresses of life, or other factors.

Furthermore, the economics of medical education are such that efficiency in the delivery of health care has become an important goal. So much money is invested in facilities and equipment which must be amortized and repaid that students cannot be put into outpatient clinics because they take too much time, reduce the volume of patients that can be seen and, therefore, interfere with the repayment of the debt associated with those facilities. In addition, those same economies lead the heads of institutions to recruit faculty who are competent in the delivery of health care and, thereby, able to generate income from it, or competent in fundamental research, again, thereby developing income. But decreasing priority is given to whether or not that person is an effective teacher or even has any interest in teaching.

Although the situation is overstated, I am convinced that medical institutions are moving in this direction. Society has defined, or accepted, two goals that are not consistent. In rate-setting States such as Maryland, there are other forces that are operational. Hospitals are competing for patients with much of this competition based upon cost. In most rate-setting mechanisms, the costs of teaching are included in the hospital's rates. Hence, in this competitive environment, there is great pressure on hospitals to reduce the expenditures for education so that their rates will be low enough to land a contract with XYZ corporation. Again, this pressure reduces the emphasis on good teaching and good education. The point is that there is not enough communication among the segments of the public health community in the definition of goals and in examining their long-term consequences. There is nothing wrong with the goal of containing the unit costs of the delivery of health care services, but in so doing the effectiveness of our educational programs must not be lessened or destroyed.

Shortcomings of Legislative Remedies

The next concern is use of the legislative route to solve health problems. Legislation has a place, but it should be to augment, not supplant, other approaches to health. Consider this example. Drunk driving has been a crime in most States for nearly 50 years. However, there was little effect until those laws were accompanied by effective educational programs. Even with those in place, the proportion of fatal accidents involving an alcohol-impaired driver is not decreasing, although the death rate from motor vehicles has fallen from 23.3 per 100,000 in 1970 to 19.2 in 1984. Today, there are numerous legislative proposals to deal with AIDS, including mandatory testing of a variety of groups of people, mandatory reporting of those testing positive, criminal charges against those who refuse treatment, and others. The fundamental questions are what role should legislation play in solving a particular problem, and what specific legislation is needed? Only if those questions are answered will it be possible to define a total program to address a public health problem.

The world of public health is an exciting, fascinating, and very fulfilling activity. It is also frustrating and conducive to cynicism. The problems seem overwhelming and there is a great tendency to blame someone, especially the government. There are hard choices to be made because our predecessors have already solved the simple ones. Current and future problems can be solved, but only if they are addressed. Each of us must think about fundamental hard choices and share these thoughts.