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United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

February 3, 1994

The President of the United States
The White House
Washington, D.C. 20500

Dear Mr. President:

I'm writing to raise again the important issue of the Administration's position on funding the public health initiatives proposed in the Health Security Act. I know you share my concern that investment in the public health system is essential to guaranteeing access to health care for low income and other disadvantaged Americans.

I understand that OMB's current budget explicitly includes these funds for 1995 but fails to assume any new funding for the public health initiatives in the last four of the five year budget period. This is contrary to the Health Security Act which includes adequate funding to cover these initiatives. If these new initiatives are to succeed, they must have new funding as provided in the Health Security Act, and it must be mandatory funding outside the discretionary budget caps.

We need a clear signal from the Administration--a letter or at least a statement--that the public health initiatives will be funded on a mandatory basis over the entire five year period. With that step, I believe we can work out specific statutory language that can pass the Senate; without that step, it will be very difficult.

Many thanks. I commend you on the effective way you've negotiated the health minefield in the past week, and I look forward to our work together on the Health Security Act this year.

With respect and warmest regards,

As ever,

Edward M. Kennedy

file public health

KINGS COUNTY HOSPITAL
BENEFITS UNDER THE HEALTH SECURITY ACT

1) **Stable and increased funding from universal coverage and blended Medicaid rates**

Under reform, reimbursement will be assured and constant as a result of the provision of coverage for the area's high numbers of uninsured and the fact that reimbursement will be the same for Medicaid patients as it is for the rest of the insured.

2) **Increased funds for research and teaching**

Under reform, the new all-payer GME and the AHC pools will ensure that Kings County receives direct payments to fund important teaching and research activities; very little direct funding is currently available to this facility now since it serves a disproportionately low number of Medicare and insured populations -- the primary source of residency support funding.

3) **New payment streams to better attract physicians**

Under reform, the patient population will be covered with private insurance and physicians will be able to bill directly for services. Direct billing will enable Kings County to attract physicians, something that this facility has had extreme difficulty in doing previously and in the future should the status quo continue.

4) **Guarantee that insurers will not discriminate against institutions disproportionately serving the poor**

It is a practical certainty that Kings County will be designated as an Essential Community Provider under HSA, which will require insurers to contract with providers in medically underserved areas. This provision will ensure that providers who have traditionally served the underserved are not discriminated against by insurers and will assure a payment stream from patients.

5) **Targeted funding for facilities that have and will continue to serve difficult to treat populations**

The Health Security Act provides for a payment stream -- known as a Voluntary Payment Adjustment -- for those facilities that have traditionally served the uninsured, including those institutions that serve large numbers of undocumented residents.

Responses to Important Concerns Likely to Be Raised by Kings County:

1) **Reducing the number of residents**. The Health Security Act proposes to limit the proportion of residencies to a certain percentage of U.S. medical school graduates (our bill does not give a specific percentage; both Rockefeller and Cooper propose limiting the number of residencies to 110% of U.S. medical school graduates). Kings County has a very high proportion of residents/ patients and they have a huge number of foreign medical school graduates.

Response:

1) They will be able to reduce the resident/patient ratio as they substitute physicians for residents since physicians will be able to direct bill under universal coverage.

2) They won't have to rely so heavily on expensive supervising MDs from affiliated medical centers to supervise their residents.

2) **Access to capital.** Because many of their health facilities are in such poor shape, many New York hospitals -- obviously including Kings County -- are in need of a great deal of capital improvement. They are concerned that funds will be even more difficult to attract as health care growth is constrained.

Response:

The city of New York will achieve substantial savings under health reform and monies as monies that currently pay for the uninsured and other services that will be covered under the benefits package. At least some of these savings could be redirected toward capital investment.

3) **Opinion on the Kings County Renovation Crisis and Relevance to Health Reform.**

Response:

Although you do not know enough to make an informed comment about the Kings County situation, facilities like Kings County will do well under reform. Coverage of the uninsured, increased funds for research and teaching, and dedicated funding streams for underserved populations are just three reasons why this is the case. (You may also want to talk about the impact of violence on the costs and demands on these facilities, and a discussion of why it is so important to pass a workable crime bill -- Moynihan should like this.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Health
Washington DC 20201

January 26, 1995

Nicole Rabner:

Enclosed are the two copies if the Shattuck Lecture, "Reinventing Public Health: A Strategy for the 21st Century," as discussed by Dr. Lee and Melanne Verveer earlier this week.

Jane M. Zopf

Jane M. Zopf
Staff Assistant to
Assistant Secretary for Health
Telephone: 202 - 690-7694

Enclosures

file Public Health

SHATTUCK LECTURE

REINVENTING PUBLIC HEALTH: A STRATEGY FOR THE 21ST CENTURY

Philip R. Lee, M.D.[1]
Assistant Secretary for Health
U.S. Department of Health and Human Services

It is an honor to deliver the Shattuck Lecture for 1994 at the annual meeting of the Massachusetts Medical Society. The Shattuck family is a distinguished one in medicine and public health, and my lecture today has its roots in the visionary work of one of its members, Lemuel Shattuck. Lemuel Shattuck was largely responsible for the recommendations issued by the Sanitary Commission of Massachusetts in 1850, in a report entitled "A General Plan for the Promotion of Public and Personal Health."(1) Charged with "ascertaining the causes which favorably or unfavorably affect the health of the inhabitants of Massachusetts", the work of this Commission ushered in the public health movement in the United States. It highlighted the importance of identifying and addressing a broad range of factors that determine health, and set the stage for the diverse and often competing interests that have to be accommodated to make substantial headway in improving health status.

In the ensuing 144 years since the Sanitary Commission's report, the public health movement has brought about dramatic improvements in the health of the American people, through such measures as environmental sanitation, immunization, communicable disease control, maternal and child health/nutrition programs, and reductions in some of the risk factors for cardiovascular disease.(2) But the course of progress has been stormy, undermined by repeated conflicts between the public health community and the medical profession. To physicians, public health measures have often been perceived as the long arm of government infringing on their autonomy, interfering with the doctor-patient relationship, and threatening their income -- both by providing patients with free services (such as immunizations) for which private physicians might otherwise be paid, and by

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[1] The ideas expressed in this lecture were developed in collaboration with Roz D. Lasker, M.D., Deputy Assistant Secretary for Health (Policy Development). Dr. Lasker also contributed to the writing and editing of the paper as submitted. Although her contributions merit those of co-author, Journal policies preclude this arrangement for Shattuck Lectures.

diminishing the need for physicians' services through reductions in the prevalence of disease.(3,4) Public health officers have generally responded to physician resistance in one of two ways: by becoming "cautious to the point of timidity", limiting their activity to non-controversial interventions,(5) or by becoming "crusaders in a cause they had to win", imposing their programs, if necessary, on an unwilling physician community.(6)

In an environment that fosters these types of perceptions, protecting and improving health is as much a turf battle between health professions as it is a battle against threats to health. This two-front war has seriously compromised the pace and extent of public health advances in the past. More important, it jeopardizes what can be achieved in the future. The multidimensional nature of current health problems requires the development and implementation of integrated strategies that capitalize on what public health professionals, physicians, and community organizations have to offer. This, in turn, requires that medicine and public health, as well as government and the private sector at multiple levels, work constructively together in the interests of a larger goal. However, as Milton Roemer commented in a related context, efforts along these lines are hardly likely to be successful as long as the economic and structural foundations of the preventive and curative health systems in this country are so strikingly opposed.(7)

Today, almost a century and a half after the Shattuck Report, the American health system is in a state of rapid and profound transformation. Although most of the attention during the last year has focused on health care reform at the federal level, profound changes are taking place independently of the Congressional process through legislative reforms that have been enacted in a number of states, waivers of regulations in federal health programs (such as Medicaid), and marketplace forces. These changes have accelerated the trend toward managed care, and are having a major impact on the organization, function, and financing of the personal health care and public health systems and the way they interact.

Although I, among many, have grave concerns about the way the health system may evolve in this environment, the changes that are occurring offer a unique opportunity to remedy some of the conflicts that currently compromise our ability to achieve public health objectives. Reforms that are being considered at the federal level and that have been enacted into law in certain states go a long way toward laying out a policy framework for a health-oriented health system -- one in which participants in all sectors are supported and rewarded for working individually and together to protect and improve their populations' health.

In a sense, this historic juncture provides an opportunity that neither the medical nor public health communities can forego. If

we fail at this time to re-orient the American health system toward health, it is likely to focus increasingly on business and profits. If we do not devote sufficient attention and resources to preventing the occurrence of avoidable illnesses and injuries, we are unlikely to be able to afford expansions in health insurance coverage or to ensure people access to expensive secondary and tertiary treatment services when they get sick.

My challenge today is to encourage the medical and public health communities to join together in reinventing public health for the 21st century. I will begin by outlining the rationale for moving toward a health system that is as supportive of protecting and improving health as it is on providing and paying for medical care. Next, I will review the barriers that stand in our way, both historically and currently. Finally, I will share what we have learned thus far in the federal and state reform debates that can help medicine and public health play more constructive and collaborative roles in achieving important health-related goals in the future.

THE IMPORTANCE OF HEALTH IN A HEALTH CARE SYSTEM

Although many physicians, and the public in general, equate the health care system with the diagnosis of disease and medical treatment, a growing body of evidence suggests that health status is largely determined by other factors. For example, in a study of factors responsible for the ten leading causes of death in the United States in 1977 and 1990, the Centers for Disease Control and Prevention (CDC) concluded that only 9.8 percent of premature deaths could have been avoided through improvements in medical care. The rest were dependent on personal risk behaviors (52.3 percent), risk factors in the environment (19.8 percent), and human biology (18.6 percent).(8) In a complementary analysis of U.S. mortality data in 1990, McGinnis and Foege attributed half of all deaths to the following factors, few of which are amenable to medical care: tobacco (an estimated 400,000 deaths), diet and activity patterns (300,000), alcohol (100,000), microbial agents (90,000), toxic agents (60,000), firearms (35,000), sexual behavior (30,000), motor vehicles (25,000) and illicit use of drugs (20,000).(9)

Another major predictor of morbidity and premature mortality is socioeconomic status. Differences in mortality by social class have been documented for over a century, and studies in the United Kingdom and the United States in recent years have demonstrated a linear relationship between socioeconomic status and health status.(10-12) In the United Kingdom, access to medical care has not reduced the impact of socioeconomic status on health status.(11)

The studies mentioned above suggest that a greater emphasis

should be placed on population-based approaches to improving health, particularly those related to behavior and the physical and social environment. Indeed, drawing on studies by McKeown (13) and others, such an approach to health policy was proposed by the Canadian Department of National Health and Welfare in 1974,(14) and by Dever in the United States in 1975.(15) In spite of these reports and the accumulating body of supporting documentation (16,17), however, the United States continues to spend all but a tiny fraction of its health resources on medical treatment. Currently, less than one percent of our health budget goes for essential population-based public health services, and proportionate expenditures for public health have actually decreased over the last decade.(18) Moreover, consistent with the predominantly biomedical focus of our research investment, we have inadequate understanding of the socioeconomic, behavioral, and environmental factors that contribute to health, and lack systematic substantiation of the impact of a large part of public health practice. These trends suggest that Dever's forecast in 1975 is still valid: "based on current procedures for reducing mortality and morbidity, little or no change in our present disease patterns will be accomplished unless we dramatically shift our health policy."(15)

Focusing on health as well as curative treatment makes sense for more than simply humanitarian reasons. Shortly after the Civil War, support for public health measures grew substantially (although transiently) because advocates were able to argue that "elimination of disease was sound economics and that infection among the poor was a potential danger to all classes".(5) These arguments should be equally persuasive today. Although not all population-based public health services save money, most are far less expensive for the benefit obtained than medical interventions. Moreover, with the development and widespread implementation of effective population-based interventions, the potential for savings is staggering. A recent analysis estimates that as much as $70 billion could be saved by the year 2000 through strategies targeted at preventing six of the nation's leading causes of death.(2) This has important implications for the personal health care system. As the country's resources become more constrained, we are in danger of not being able to afford expensive medical treatment unless we improve our ability to prevent avoidable illnesses and injuries from occurring in the first place.

CURRENT BARRIERS TO PROTECTING AND IMPROVING HEALTH

Both the medical and public health communities have important roles to play in maintaining and improving health, as do individuals and a broad range of public and private organizations at federal, state, and local levels.(19) In the current environment, however, longstanding structural and attitudinal

barriers prevent each sector of the larger health system from fulfilling its potential in this regard or from working constructively together.

Treatment-Oriented Payment Policies

Historically, the fee-for-service payment system in this country, in which practitioners get paid more when people are sicker and require more medical services, has proven to be the most important source of conflict between medicine and public health. As early as the beginning of the 19th century, physicians in private practice balked at any public policy or facility geared toward providing medical services to patients from whom they might otherwise be paid. Resolutions were introduced in numerous cities denouncing free medical care provided by dispensaries, hospitals, and medical college clinics.(5) Similar opposition was voiced about the provision of care at well-baby clinics, health centers, and social agencies, such as settlement houses. (5) In Brooklyn, for example, physicians signed a petition protesting the successful establishment of baby health stations in New York City by the Bureau of Child Hygiene because they were "ruining medical practice."(20) Efforts at mass immunization were vigorously resisted, since immunizing children was a "simple and lucrative source of income."(5) Even the Sheppard-Towner Act of 1921, which authorized federal grants to states to promote the health of mothers and children, was actively opposed by the American Medical Association (AMA). "Maternal and child care necessarily involved some measure of curative medicine, and the profession was determined to prevent any infringement upon private practice."(5) Although unsuccessful in stopping passage of the original Act, the AMA lobbied successfully against its reenactment in 1929.

Clearly, public health's direct involvement in the provision of medical services was the most explicit threat to physicians' incomes. Nonetheless, many physicians saw all public health measures as an "assault on their interests."(4) As Wickliffe Rose commented in describing physician resistance to the work of the Rockefeller Foundation eradicating hookworm in the South at the turn of the century: "A physician has to make a living, but that depends on the prevalence of disease. Insofar as this function (prevention) is successful it diminishes the prevalence of disease and therefore diminishes his work and his income."(4)

With the trend toward managed care and capitation, financial incentives in the medical system are becoming more oriented toward health. But currently, there is no mechanism to ensure that practitioners or managed-care plans respond appropriately to these incentives. Capitation can have the undesirable effect of encouraging certain providers to forego necessary services, including preventive services that are not cost-effective in the short term or whose savings do not accrue directly to them.

Lack of Accountability for Clinical Care

One of the reasons that the public health system became directly involved in the provision of personal health care services is that there was, and still is, no way to ensure the universal delivery of medical care through the private sector. Consequently, without public intervention, there has been no way to achieve public health objectives that rely on individual medical services to protect the health of the community (for example, immunizing a sufficient proportion of the population to achieve herd immunity, or controlling the spread of treatable contagious diseases, such as tuberculosis).

Three characteristics of the health system contribute to this problem. On the one hand, not everyone can afford medical care, and the extent of uninsurance and underinsurance among the American population is high and rising. At the present time, 58 million Americans are without insurance at some point during the year(21), 55 million are underinsured to the point where a significant illness could place them in bankruptcy(22), and 81 million have pre-existing conditions that insurers use to raise rates or deny coverage at the time of diagnosis or when changing jobs.(23)

For those lucky enough to have health insurance coverage, benefits cover the treatment of acute conditions and complications of disease far more frequently than preventive services. These types of policies send a distorted message to patients and practitioners, discouraging them from playing an active role in prevention. They imply that preventive services are somehow of less value than treatment services. And they reinforce the natural disinclination to seek out and implement clinically effective preventive care when an individual feels well. This contributes to the inadequate delivery of primary preventive services, such as immunizations, and to the limited application of difficult and time-consuming secondary or tertiary preventive care, such as intensive insulin therapy in patients with insulin-dependent diabetes.(24)

Finally, and perhaps most important, no practitioner or entity in the American health system is responsible for making sure that people are aware of or get the medical services they need to keep themselves and their community healthy -- even when patients have insurance coverage including generous preventive benefits. In fee-for-service settings, medical care is oriented toward those who actively seek out care, and the care that is provided tends to be fragmented. Unlike some countries with this type of payment structure, individuals do not join the "list" of a particular family doctor. Instead, patients choose practitioners on the basis of the symptoms they are having, and often see multiple practitioners, who may not be in sufficient contact with each other to effectively coordinate care. Under these

circumstances, it is not uncommon for asymptomatic individuals to miss getting necessary preventive services, for one practitioner to assume incorrectly that another is providing his or her patient with a particular preventive or treatment service, or for different practitioners to be providing a given patient with duplicative services or conflicting drugs and care.

The rapidly growing managed care environment would seem to be more supportive of accountability, since managed-care plans have defined lists of enrollees. But for some enrollees (for example, Medicaid recipients, and workers who change jobs or whose employers change insurance options every year), the duration of coverage with any given plan is short or coverage is intermittent. Consequently, it may not be possible to hold a plan responsible for providing a full episode of preventive care (such as all indicated immunizations by the age of two), and it may not be financially worthwhile for a plan to do so. Even with longstanding enrollment, there is currently no public system for assessing health plan performance. Existing incentives make it more lucrative for managed-care plans to select healthy populations than to keep their enrollees healthy. In this context, health plans develop "report cards" primarily to serve as marketing tools.

Erosion of Population-Based Public Health

The population-based services that public health agencies and community organizations provide can be extremely helpful to the medical system, both by supporting clinicians in realizing their professional goal of keeping their patients as healthy as possible, and by making it possible for managed-care plans and other payers keep health care costs under control.(19,24,25) For example, community-wide education and media campaigns can substantially reduce personal risk behaviors (such as sedentary behavior, poor eating habits, and smoking) that contribute to the development of many chronic illnesses. Activities to protect the food supply, water, and the environment can prevent diseases due to toxins and contaminants, which can affect everyone in a community and are potentially life-threatening in certain subgroups. Public health surveillance can alert practitioners to emerging infectious and environmental threats to health, allowing them to target preventive, diagnostic, and therapeutic services.

In spite of the importance of population-based public health services, years of neglect are compromising the capability of many communities in the United States to provide them. Most providers and consumers think of the public health system only in terms of providing medical services to the poor. Few have a clear understanding of the population-based functions that national, State, and local public health agencies perform or how these functions can support them. Moreover, there are few

incentives in the current system for the medical and public health communities to learn about each others' activities and work together.

This lack of knowledge has limited the development of an effective constituency for public health, with serious consequences. Increasing pressures to provide medical care for the indigent and uninsured coupled with chronic underfunding have seriously eroded the capacity of State and local public health agencies to fulfill their community-wide responsibilities. As a result, old health problems are re-emerging, avoidable epidemics of water- and food-borne illnesses are occurring with increasing frequency, and some of the unhealthy personal behaviors that contribute to the morbidity associated with numerous chronic diseases are also on the rise.(26) Confronting this deterioration in the infrastructure for population-based health in 1988, the Institute of Medicine declared public health in the United States "in disarray."(27) The American Public Health Association reiterated IOM's conclusions in its 1993 report, Public Health in a Reformed Health Care System: A Vision for the Future.(28)

Attitudinal Barriers

There is no doubt that closer collaboration between the medical and public health communities would make it possible to achieve public health objectives more effectively and efficiently. Yet, over the past century, repeated attempts to bring these cultures together have almost always failed.(4) In the 1930's, for example, educators promoted the integration of prevention and curative medicine. Students in a number of medical schools worked from a specific clinical case back to its underlying causes in the community. They were expected to confront all aspects of disease in their treatment syntheses and to interact with social service, public health, and community agencies in the prevention and cure of disease. Such an approach to education made public health and preventive medicine relevant to medical students. But by the 1940's, responding to concerns that too few hours were explicitly directed toward public health, the focus reverted to environmental sanitation, which failed to excite most students.(29)

The growth of professional schools of public health in this country institutionalized the culture gap between medicine and public health. This gap has been exacerbated even further by the imbalance of resources between the two fields, which has increasingly drawn physicians toward specialties centered around emerging diagnostic and therapeutic technologies rather than preventive medicine, and has created within the public health profession "a sense of virtue and dedication unrewarded."(30)

Molly Coye has outlined a series of attitudinal barriers that

have made public health its "own worst enemy" in achieving health objectives.(30) Among these are a sense that public health is entitled -- without justification or accountability -- to a level of support it does not currently receive; scorn for any consideration of cost-effectiveness; ignorance of ways that the medical sector can support public health in achieving health-related goals; and general contempt for the private sector. The culture of government has been an additional barrier. Public health agencies are typically governmental bureaucracies with limited ability to respond quickly to changes in the environment. Categorical approaches to program design and implementation can be burdensome and limit local flexibility in dealing with multifactorial community health problems.

KEY ELEMENTS TO REORIENT THE HEALTH SYSTEM TOWARD HEALTH

In the health care reform debate that consumed the country for much of the last two years, the attention of policymakers and the general public was focused primarily on issues related to the accessibility and financing of health insurance. Ultimately, however, neither the federal government nor the states will be able to address these problems successfully without also dealing with their populations' health. Health security, which has become a byword of reform, is more than guaranteed insurance to pay for the costs of medical care. Americans also deserve the assurance that their health care system has the incentives and capacity to protect them from a broad array of threats to health and to prevent illness and injuries from developing in the first place.(26) If we are not successful in the latter endeavor, we may not be able to afford the former.

The economic, structural, and attitudinal barriers that I outlined above have created unnecessary conflicts among the various sectors of the health system, limiting their ability to work constructively together in achieving health-related goals. Protecting and improving health is the foundation of all health professions, and the accomplishments that have been achieved thus far are a testament to the contributions made by a broad range of clinicians and public health professionals, in academia and practice, in both the public and private sectors. But unless we find ways to overcome existing barriers, and to actively encourage the medical and public health communities to become "partners in health", we are unlikely to make substantial strides in dealing with the complex, multifactorial, and interrelated problems -- such as violence; alcohol, tobacco, and drug abuse; teenage pregnancy; AIDS; drug-resistant tuberculosis; chronic disease; accidents; and environmental and occupational hazards -- that threaten our health and financial resources at the threshold of the 21st century.

An important lesson of the 144 years since the Shattuck Report is

that little progress will be possible if we continue to think of medicine and public health as separate systems, one focused on diagnosis and treatment, the other on protection and prevention. Instead, we need to bring these disparate cultures together as complementary parts of an integrated, health-oriented, health system. That is what I mean by "reinventing public health." Although this aspect of health reform was not highlighted by the media during the recent debates, considerable progress has been made nonetheless. Two states, Washington (31) and Minnesota (32), recently enacted legislation that not only makes improving the population's health an explicit goal of reform but also supports achieving this objective through a broad range of policies. At the federal level, both the President's proposed Health Security Act (33) and reform bills voted out of the Senate Labor and Human Resources Committee (34) and the House Education and Labor Committee (35) contained numerous elements that, had they been enacted, would have dramatically reoriented the American health care system toward health.

All of these bills include a common and comprehensive set of strategies which seek to overcome existing barriers to protecting and improving health. Although the Congress was not successful in enacting health reform this year, and some of the achievements in the states of Washington and Minnesota are currently under siege, the work that has been done thus far goes a long way toward laying out the policy framework for a health-oriented health system. Taken together, key elements included in these bills:

- restructure the personal health care system, making it a more active, unconflicted, and accountable participant in achieving health objectives;
- redefine the public health system, by strengthening its capacity to deliver population-based health services and by fostering better collaboration with other sectors involved in health; and
- build up the capability of all sectors to address high priority health problems through support for training, research, and information systems.

Restructuring the Personal Health Care System

History suggests that restructuring the personal health care system is the linchpin in any health-oriented reform. Ultimately, resolving the economic conflicts and turf battles between the medical and public health communities, and building a vigorous constituency for health, depends on three factors: achieving universal health insurance with full coverage for clinically effective preventive services; instituting payment

systems that explicitly reward efforts to maintain and improve health; and moving toward a more accountable system by clarifying responsibility and assessing performance in the delivery of care.

Expanded access to personal health care services. As I discussed earlier, public health involvement in the delivery of medical care is, in part, due to the inadequacy of insurance coverage and the predominantly treatment-oriented benefits policies for those who are insured. Consequently, a common provision in all of the health-oriented reforms mentioned above is universal health insurance covering comprehensive benefits, including preventive services. Ideally, to encourage individuals and practitioners to play a more active role in prevention, all primary, secondary, and tertiary preventive services documented to be effective would be provided without any cost-sharing for those in need.

At the national level, attempts to enact universal health insurance failed this year (as they have repeatedly in the past) because the three principal financing options -- employer mandates, individual mandates, and federal taxes -- all engendered fierce political opposition. Although some states are trying to move toward universal coverage and some are considering including secondary and tertiary as well as primary preventive services in their benefits package, these objectives are proving difficult to achieve without supportive federal legislation.

With the fallback position -- incremental expansion of health insurance coverage -- it may not be possible to resolve the conflict between medicine and public health in the delivery of care. States are increasingly seeking federal waivers to allow them to enroll a broader range of beneficiaries in Medicaid managed care. But in some cases, eligibility may be too intermittent for public health to rely on these plans to provide preventive services. Other states, and perhaps the Congress this year, are attempting to expand access to insurance by outlawing insurance practices that discriminate against people with pre-existing conditions and by making insurance more affordable for small employers and the self-insured. But without universality or mandates, healthy people may choose not to purchase health insurance, and some employers may stop paying for coverage for their employees. If this happens, asymptomatic individuals may not be willing to pay out of pocket for preventive services. And people with existing and expensive illnesses may find themselves eligible for insurance, but no longer able to afford it. With such a scenario, there could be more need for public health to be involved in the delivery of medical care, exacerbating current conflicts.

Even if more people have access to insurance coverage, it does not necessarily mean that they will have access to clinical care, especially if they live in underserved rural and inner-city neighborhoods. Recognizing this problem, all health-oriented

bills include some set of provisions to help practitioners and health plans expand into underserved areas, and to increase support for the outreach and enabling services (such as transportation, translation, and child care) that many people need to use the health care system effectively.

Health-oriented payment systems. All of the health-oriented reforms that I discussed above capitalize on the current trend toward managed care. They take this tack because, in spite of its well-documented problems, managed care establishes for the first time a foundation for holding the personal health care system responsible for defined populations, and utilizes a payment scheme that explicitly rewards health.

With payments based on annual premiums covering total patient care, health plans benefit financially to the extent that either they or the public health system keep their enrollees healthy. Potentially, this gives health plans an incentive to ensure that their enrollees are aware of and have access to cost-effective preventive services. Equally important, it can encourage them to work with and support the efforts of public health agencies and community organizations, which can prevent unnecessary disease and health care costs through community-wide interventions. Realizing the benefits of this type of payment system, however, requires concomitant safeguards (such as insurance regulations and performance monitoring) to assure that health plans do not reap financial benefits by enrolling low-utilizing populations or denying their enrollees necessary care.

Health plan performance monitoring. From the point of view of accountability, the most important reform element related to the personal health care system is a public program of health plan performance monitoring, or report cards, that focuses the attention of health plans on achieving healthy outcomes for their enrollees and monitors how well they accomplish these goals. Public measurement of health plan performance is very different from plan-sponsored report cards that are designed to be used as marketing tools.

Although most of the discussion about report cards has centered around their function in supporting employer and consumer choice of health plans, their usefulness can be considerably broader. A public system of report cards can focus the attention of health plans, providers, and consumers on what we, as a nation or a state, want the health system to accomplish. Important health goals, such as those related to immunization, can continuously be highlighted, whether or not government agencies or public interest groups conduct yearly campaigns.

Report cards can also help the personal health care system focus on populations, not just individuals. The performance measures included in report cards are rates, involving both a numerator

and a denominator. The denominator includes all relevant enrollees in the health plan, not just those who seek out care. (For example, a performance measure related to childhood immunization could include all children enrolled in a plan between the ages of 0 and 2; a measure related to glycemic control in noninsulin-dependent diabetes could include all enrollees diagnosed as having that condition). The personal health care system has not paid much attention to denominator populations in the past. That may explain why certain plans willingly accept indigent populations who do not seek out care. It is also one of the reasons that the provision of preventive services, such as mammography and immunization, has been low in many fee-for-service and managed-care plans, even when these services are included in the benefit package. Employer-driven report cards are beginning to encourage responsibility and accountability in managed-care plans, resulting, for example, in substantial improvements in immunization rates. The public health community would have much greater confidence in the ability of health plans to deliver important preventive and therapeutic services if appropriate performance measures were developed and implemented at national or state levels.

Finally, in this time of rapid change, performance monitoring can serve as an important quality safeguard, ensuring that health plans are more than business ventures focusing on profits. Fixed annual payment systems reward health plans for keeping their populations healthy but they can also create incentives for plans to deny enrollees access to appropriate but expensive services. Moreover, some services that are needed to keep individuals or their community healthy do not become cost-effective until many years later, when patients may have moved on to another health plan. A public system of report cards is an essential element to ensure that all health plans do their part in providing clinically effective care, which is ultimately of as much benefit to other health plans and the health of the community as it is to individual enrollees.

Strengthening and Redefining the Public Health System

Restructuring the personal health care system in the ways outlined above would be expected to substantially improve the delivery of clinical preventive services by the personal health care system. Ultimately, however, making a substantial impact on the health of the population and controlling health care costs depends on having the capacity to change personal risk behaviors (such as those related to diet, exercise, and smoking), to support people who attempt to sustain these difficult changes in lifestyle, and to prevent avoidable injuries and illnesses due to infectious agents and environmental hazards. The medical community cannot be expected to accomplish these tasks alone. Individuals, practitioners, and health plans deserve the support of a strong public health system capable of delivering a wide

variety of population-based services. These services include community-action programs, such as community-wide education and media campaigns targeted to high-risk groups; social and economic policies, such as those establishing smoke-free zones and implementing taxes on cigarettes; and essential community services geared toward protecting the environment and detecting and responding to epidemics and other health emergencies.

Indirect policies. Building up the capability of communities to carry out these functions depends, in two important ways, on reforms that restructure the personal health care system. Without expanding health insurance coverage, the public health system will not be able to move away from providing medical care to the indigent and uninsured and concentrate instead on the task for which it is uniquely qualified: providing population-based community health services. Without a substantial shift in financial incentives and the introduction of a strong system of accountability, neither the general public, providers, nor payers are likely to support the increases in federal and state funding that are required to adequately deliver these services.

Explicit policies. Reforms need to go further than restructuring the personal health care system, however, if the currently weakened public health system in this country is to be reinvigorated. Distinct policies are needed to strengthen the infrastructure for delivering population-based services at State and local levels and to encourage the public health and personal health care systems to work constructively together. If not addressed explicitly, marketplace or legislative reforms could further compromise the deteriorating public health system. For example, in some states, population-based public health activities are indirectly supported by funds for personal health care services, such as Medicaid. As care of Medicaid patients is shifted from public health providers to the private sector, funds for population-based services may inadvertently disappear.

State reforms and Congressional bills use two types of approaches to strengthen the capacity of communities to protect and improve the health of their populations. First, they provide State and local public health agencies with more flexible, noncategorical sources of funds to support essential population-based public health functions. (Without a restructured personal health care system or an active constituency for public health, it has been difficult to assure secure funding for these programs, however). Accountability is fostered by monitoring the performance of public health agencies in carrying out essential functions and in meeting specific standards, much like the use of report cards for health plans.

Second, recognizing that public health agencies are not optimally effective working in isolation, the reforms actively foster collaboration between these agencies and other entities that can

make a contribution toward improving health. Clearly, better linkages are needed between public health agencies and a broad range of private and public health care providers. But community-based organizations, employers, churches, and service clubs can also be valuable partners, as can government agencies outside of the traditional public health structure that deal with auto safety, occupational health and safety, air and water pollution, toxic wastes and other environmental hazards. Some of the reforms rely on structural mechanisms (such as regional coordinating boards in Minnesota), to bring these diverse groups together. Others use financial incentives, funding partnerships among groups to develop integrated strategies for addressing high-priority local health problems.

Workforce, Research, Information Systems

Even if current economic, structural and attitudinal barriers are overcome, the ability of communities to protect and improve the health of their populations will still be limited by three factors: the adequacy of their workforce, the extent of available knowledge, and the ability of various participants to obtain the information they need and to communicate effectively with each other. Because it is neither efficient nor feasible for local jurisdictions to deal with these issues alone, the federal government has important contributions to make in each of these areas.

Workforce. The health workforce, which accounts for almost 1/12 of all employed workers in the United States, is the backbone of both the personal health care and public health systems. Ample evidence has been accumulated about workforce issues that must be addressed in medicine and the allied health professions (36-38), and these issues were explicitly addressed in various federal proposals for health care reform and some state reforms as well. But far less attention has been paid to the need for training in population-based health.(39) There are serious shortages in some public health specialty areas (epidemiology, for example) and many individuals in the current workforce need further training to effectively assess health problems and implement population-based strategies for improving health. To build a workforce to support a truly health-oriented system, we need to train a number and mix of public health and personal health care professionals that reflect the needs of the system and the diversity of the population. Equally important, these professionals need to be trained to work effectively together, linking population-based health and clinical care.

Research. Prevention research is the foundation for both clinical preventive services and population-based health interventions. Our substantial investment to date, however, has focused far more on biomedical approaches to prevention than on the elucidation of behavioral, socioeconomic, or environmental

factors that contribute to health or on evaluating the costs and effectiveness of population-based services. Lack of adequate methodology and knowledge in these latter areas diminishes the likelihood that we will identify and focus adequate resources on the most important determinants of health, or that highly effective population-based interventions to address these determinants will be developed and disseminated.

Most of the federal proposals for reform included policies to expand current funding for prevention research. To adequately support a health-oriented health system, however, future investments need to support a balance of focused and multidisciplinary research in a broader range of areas: basic biological science, clinical medicine, public health practice, behavioral and social sciences, epidemiology, health systems and services, and occupational and environmental health.

Information systems. All participants of the health system rely on information to define health problems, assess performance, support decisionmaking, and take timely action to protect and improve health. Currently, the American health system collects enormous amounts of data. But because the same information is reported in hundreds of different ways and local information systems cannot communicate with one another, the burden on both medical and public health providers is great and the information that is generated is not as useful as it could be.

A strong consensus about the features of a health information network is currently emerging among members of both political parties as well as the major stakeholders, and improvements in health information have been highlighted in both federal and state reforms. At the federal level, most bills envision a public/private partnership in which the private sector owns and operates the bulk of the system and the federal government establishes the overall policy framework, including nationally uniform standards for reporting and electronic exchange of data; unique identifiers for individuals, health plans, and providers; and strong privacy and security protections. This type of national framework can promote administrative simplification and enhance the usefulness of information in several ways: by creating a standardized clinical vocabulary and coding structure for health information, by assuring a secure environment for the transmission and exchange of health information, and by enabling information routinely collected in the delivery and payment of health care to be used for other health-related purposes (such as promoting access and quality of care, achieving public health objectives, and advancing medical research).

CONCLUSION

As we stand at the threshold of the 21st century, the American health system -- like the Sanitary Commission of Massachusetts in 1850 -- is faced with ascertaining the causes that affect the health of the American people and targeting our limited resources to successfully address them. The factors determining health today are far more complex than those faced by Lemuel Shattuck, demanding the close collaboration of multiple sectors in the development and implementation of interdisciplinary health strategies. But although we have seen substantial advances in medicine and public health in the last 144 years, the two professions are no more able to work together in achieving common health goals now than they have been in the past.

Problems with the structure and organization of the personal health care system make it impractical for the public health system to rely on private practitioners to deliver preventive and therapeutic services that are essential to protecting community health. Moreover, because of distorted economic incentives, these practitioners have repeatedly opposed public health's direct involvement in the delivery of medical care, as well as population-based interventions that reduce the prevalence of disease, diminishing the need for medical services.

In spite of the importance of population-based interventions in addressing the broad range of factors that determine health, the ability of communities to provide these services has been eroding. The increasing number of indigent and uninsured is part of the problem, but so is the lack of knowledge among Americans about what public health agencies do, and the lack of supportive financial incentives in the medical system. In this context, public health has become its own worst enemy, withdrawing rather than reaching out to policymakers, the public, and other sectors of the health community.

The dramatic changes that are currently occurring in the American health system offer us an opportunity to remedy some of these conflicts and imbalances. In fact, it is imperative that we do so if we are ultimately to improve health status and get accelerating health care costs under control. A prescription for a more health-oriented health system was proposed in various health care reform bills at the federal level and has begun to be implemented in two states. The set of strategies common to all of these bills ameliorates the economic and turf battles between medicine and public health by moving toward universal coverage with full coverage for preventive benefits, and by capitalizing on the current trend toward managed care to institute health-oriented payment systems, responsibility for defined populations, and accountability for medical care through a public system of performance measurement. It strengthens the capability of the public health system to provide essential population-based health

services by increasing financial support, enhancing the flexibility and accountability of that support, and fostering better collaboration among the broad range of public and private sectors involved in health. Finally, it supports the infrastructure for a health-oriented system by supporting the development of integrated information systems, and by moving toward more balanced workforce and research policies.

Experience in states that are implementing these reforms suggests that health-oriented policies can engender desirable changes in practice. For example, some managed-care plans in these states have begun to seek out the help of public health agencies in reducing behaviors that put their enrollees at risk of developing chronic illness. Others have begun to make overtures to the medical community regarding appropriate standards of care for particular populations of patients. Some public health agencies in these states are using health plans as a channel to inform and educate individuals and practitioners. Health plans and public health agencies have begun to identify common goals (such as those relating to tobacco use, communicable disease control, chronic disease control, health education and community mobilization, maternal and child health and reproductive health) and to delineate respective roles and responsibilities. Finally, health plans have begun to support public investment in the infrastructure to support population-based health. In spite of these encouraging reports, however, it is important to emphasize that changes in practice are not coming easily. Medicine and public health are two very distinct cultures. Consequently, it is not surprising that overcoming attitudinal barriers is requiring far more than changes in policy.

As the process of reform in the United States continues, many levers will be available for moving the health agenda forward. For example, national health reform in some guise is almost certain to resurface in the future. States are increasingly learning from each other; consequently, it may be possible to extend to other states the types of health-oriented reforms that have been enacted in Washington and Minnesota. And both states and the federal government can take advantage of nonlegislative initiatives, such as the Medicaid waiver process, to re-orient the system toward health. Realizing the potential of these opportunities, however, will require the medical and public health communities to join together in support of their common professional goal. Incremental policies that change economic incentives and foster accountability can provide the necessary impetus to make this happen.

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