Health Healthcare

Opening Session of the
Oregon Public Health Association Annual Conference
Portland, Oregon

Oregon's Future periodically organizes public panel discussions on complex and controversial topics important to the community of Oregon. The following edited excerpts demonstrate the differing priorities and considerations of practitioners, administrators, industry, and government representatives—all key players in determining healthcare policy in Oregon. The Panel was sponsored by Community Health Partnership.

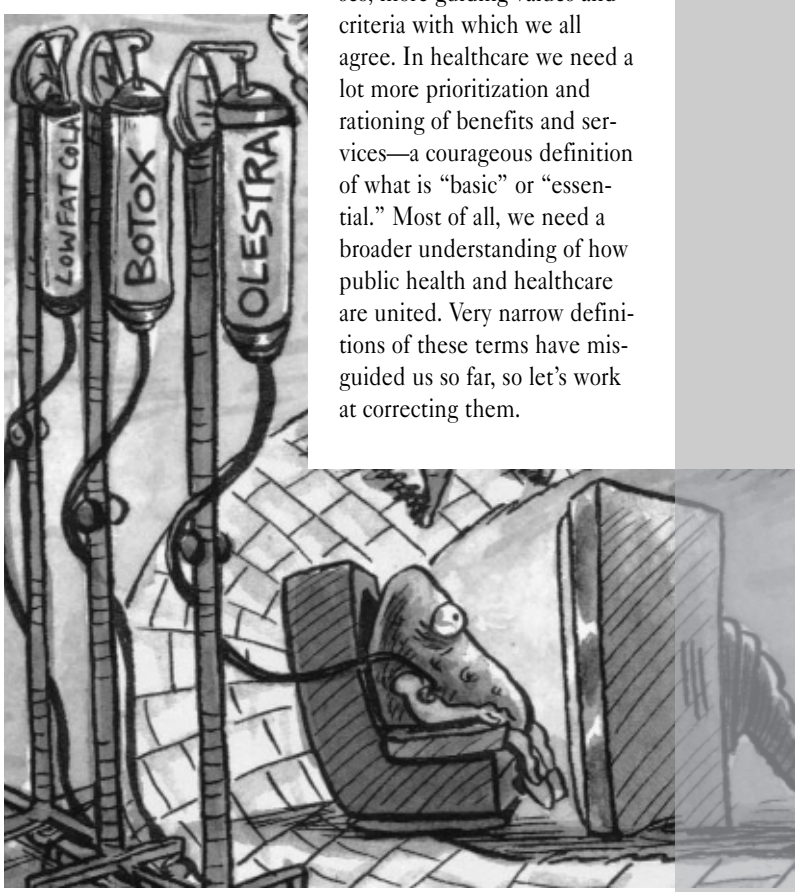
Andrew Holtz, MPH
Moderator,
Independent Healthcare Journalist

Public Health versus Health Care, what a provocative title. We have to decide all the time where we put our resources and we have a packed panel of professionals from diverse disciplines to discuss this tension. So lets get started with opening comments.

Tina Castañares, MD
Family physician, medical director for migrant and community health centers

Good morning. I'm happy to start off, and I'm somewhat infuriated by the name of the topic, so I guess that's a good place to start. This distinction between public health and healthcare has been made through historical accident and convention. Certainly there is a spectrum of things which belong clearly in the realm of public health and another in the realm in healthcare. For example, Botox injections would be hard to regard as public health. But for most of us in this line of work, there is no bright line and we should not let ourselves become trapped or competitive due to dubious distinctions. As I did in my article for *Oregon's Future*, I would like to urge that we use a metaphor drawing on ecology when we think about health and how to optimize it. We need to think holistically about individuals' health, and about systems to promote community and population health. I fear that we in public health and healthcare are very poor students of ecology. We tend to address issues in very small bites, not addressing the whole picture.

We display almost a willful ignorance of reality when we do things like these: healthcare providers giving out pizza coupons to kids after immunizations; safety net clinics using outreach vans with a fast food company logo on them; hospitals polluting their communities' air or water by their incinerators or other waste processes; public health and insurance programs and initiatives (like Medicaid) excluding people on the basis of their immigration status; insurance paying for deliveries but not birth control or prenatal care; dedication of a huge proportion of our healthcare spending to people in their last few weeks or days of life; governmental support of corrupt drug patent protections and pricing mechanisms at the same time that another branch of government is struggling to make prescription drugs affordable; reimbursement practices which reward medical error and also reward the refusal of needed care to needy patients.



So there is a lot of room for policy improvements and for new thinking. I think when it comes to policy work, we have to leave our hats at the door. And to do this is tricky. Really, each one of us wears every hat—provider, consumer, patient, insurer, payer, citizen—and that's why it's so important for us to leave those hats, our most narrow biases and self-interest, at the door when it comes to framing public policy together, for the good of all. *Your* interest in your health is also *my* interest in your health, and vice-versa. We need more sophisticated analyses, more guiding values and criteria with which we all agree. In healthcare we need a lot more prioritization and rationing of benefits and services—a courageous definition of what is "basic" or "essential." Most of all, we need a broader understanding of how public health and healthcare are united. Very narrow definitions of these terms have misguided us so far, so let's work at correcting them.

Health Update

Colin R. Cave, MD
President, Oregon Medical Association

Good morning. We have seen a national trend toward increased funding for public health. The fear of bio-terrorism has increased our understanding of the need for public health agencies, but the work these agencies do goes well beyond that. We have also seen 40,000 people lose their Oregon Health Plan funding this year with the adoption of the new budget. We would love to get them covered again. Thus, there are many good reasons to funnel more money to both public health and actual healthcare. I will let the others debate the wisdom of how much should go to which. My job today is to let you know that, if current trends continue, there may not be enough of a physician workforce in the near future to achieve either the goals of our public health agencies or the groups that care for patients on a clinical level. First, we need to quickly look at the factors leading up to our current situation. These include Medicare, Medicaid, the liability crisis, and our problems with recruitment.

Oregon has always been an efficient state in providing medical care. For this we have been penalized financially by the Federal Government, with more expensive states getting higher adjustments every year. The sustainable growth-rate formula remains fatally flawed with another 4.4% reduction anticipated in 2004 if no action is taken. Regarding Medicaid, the Oregon Health Plan used to be a model for the country. Now, physicians lose money whenever they see an OHP patient. You can't make that up in volume.

Regarding the liability crisis, we had a stable environment from 1987-1999. The Oregon Supreme Court overturned caps on non-economic damages in 1999, and things haven't been the same since. We have seen a 400-percent increase in payments from 1999, directly attributable to the efforts of a small number of personal injury lawyers. Some obstetricians (OB) have seen a 300-percent increase in their premiums in just a few years. We have lost 125 providers or 22 percent of those delivering babies. This increases the stress on the entire system, and raises serious concerns about maintaining the safety of our patients. It takes years to replace an OB or a family practitioner who delivers babies. You don't just get tort reform and see these doctors start to deliver babies again after a few years of not doing so. Nearly half of the brain surgeons don't do brain surgery any more.

Regarding recruitment: For all of the above reasons, we cannot replace our doctors. Every doctor that we can't recruit to this state is the same as losing one. ACOG warns their residents not to come to Oregon. New OB's who want to come here may not even be able to find affordable insurance. *(ACOG it the American College of Obstetricians and Gynecologists—a nonprofit organization of women's health care physicians —Ed)*

What kind of effect, exactly, is it that we see today? Here are some highlights of our recent Physician Workforce Survey. We had a huge and statistically significant response of nearly 5,000 doctors. The survey confirms our fears about the current and future loss of access to medical care for Oregon patients. Over 10 percent of Oregon doctors do not accept new patients; 40 percent don't accept new Medicare or limit acceptance of Medicare patients; 20 percent of physicians don't accept OHP patients; 10 percent of physicians in Eastern and Southwestern Oregon have already closed their practices or will definitely do so. The big ones: one-in five physicians in this state plan on retiring within the next five years. That increases to 37 percent planning retirement when we ask our neurosurgeons. One-in five of our physicians under age 49 are considering moving out of state—40-49 years of age are classically considered to be physicians in their peak productivity years. These numbers are unprecedented. This has led to physician burnout in those still practicing. And our fulltime doctors aren't the same fulltime doctors as 20 years ago. This equates to full-time employee cutbacks—more physicians but more part timers because they are experiencing less satisfaction at work and more with their families. Job sharing means two physicians but only one full-time employee.

The answers to recruiting and retaining a highly skilled physician workforce are many. We are addressing them on all fronts. But where there is no more money available for increased OHP funding or public health funding, there is still

one thing that can address this problem; We need to pass common-sense legislation to control awards on non-economic damages, while assuring injured patients of full economic recovery and maintaining the jury system. This won't be the whole answer, but it will help to stem the flow of physicians who are and will be needed to meet the ends of both our clinical and public health colleagues.

Thank you for your attention.

Donalda Dodson, RN, MPH
Administrator, Office of Family Health

I am here to tell you about public health nursing. When I first got his assignment I thought that public health nursing is the answer to the problem of understanding these two areas. Public health nurses keep their feet in both boats. Public health nurses assist in direct care as well as preventive public health. Public health nurses are in a position to help in both of these areas because of their knowledge of nursing, of public health science, and because of their population-based approach to healthcare—whether it's direct or preventive care. I think the best way to get this message across is to tell a story.

Public health nurses are in the community, they work with families, and they hear what the families have to say. This assists us in identifying the needs of the community. From such interaction we determine how may families have the same concerns. We use this information to prioritize the health issues of the community. We then facilitate activities that give attention to these within the community. An example is that in one small community public health nurses noticed infants with rashes, these rashes were not responding to treatment, so the babies were referred to acute care. This small epidemic turned out to be the beginning of a neonatal syphilis Epidemic and public health nurses connected the dots.

Home visiting activities, have resulted in families having as much as 80-percent less protective service for children and 40-percent less contact with the justice system.

Public health nurses working in the community help apply the principles of preventive medicine and acute medicine. They promote the concept of preventive health. These nurses act as facilitators, catalysts, and conduits for services. We identify the needs of the community and address them with action.

Bruce Goldberg, MD
Administrator,
Oregon Health Policy & Research

Like Tina, I was quite infuriated by the topic, having spent the last 25 years of my career standing in the breach between public health and medical care. The fact that we'd actually be talking about it this morning is really an indictment of the healthcare system

You know, we can in many ways continue to argue about public health vs. healthcare, but I think it is time to change, for the last century has seen tremendous accomplishments for both healthcare and public health, including life-expectancy increases from 45 years at the turn of the century to 75 years now. Never in 4000 years have we seen such a change. It's not that way everywhere in the world but it certainly is that way here.

We now have the tools of population - based health at the fingertips of healthcare providers all around the state. I think that brings us closer to our medical-care providers becoming population-based health providers.

Bruce Goldberg, MD

We have eradicated small pox and we are on our way to eradicating polio. We've really seen tremendous advances. We can treat leukemia that people died from ten years ago. We have developed surgical techniques. People now, who have renal failure, lead long and productive lives. And we've got a lot of new problems: we have obesity, we have the marketing of tobacco, which has become a huge public health problem, and we have chronic diseases. These have complex interactions, and keeping people healthy is extremely complex.

To be healthy really depends on individual factors: (age gender, and clearly our genetic make up), personal behaviors, and environmental factors. And when I speak about environmental factors its not just about clean air and clean water, but also social factors (how connected we are in our communities); political factors, (whether we are at war or at peace); economic factors, (whether we have jobs or not.) Think about how we can put all those together. We have to work together. Medical care can only address one piece of that, really only the identification and treatment of disease. Public health has historically addressed the other part, the prevention and assurance function. But we know that we are out of whack and out of balance in terms of how we address these issues. Ninety-five percent of our healthcare dollars go to spending for individual medical care.

We've really got to switch that balance and there are number of forces that are coming together to actually bring us together. Two issues: One is chronic diseases and the other is computers. We now have the tools of population-based health at the fingertips of healthcare providers all around the state. I think that brings us closer to our medical-care providers becoming population-based health providers. At the same time, we see public health getting involved in chronic-disease prevention. And indeed, what we see is public health taking on the role of preventing chronic disease and how to prevent tertiary complications. I think we have come to a time

when we must bring together public health and individual care and it's time we stopped speaking of them as being separate.

Albert Einstein reminded us that provincialism is indeed an infectious disease, actually an infantile disease. He actually he was referring to nationalism, the measles of mankind. I think what we have learned is that we must work together and that the power and independence of our disciplines will be achieved through consenting to interdependence. Having said this, let me point to some areas where we may be able to make some investments. Number one, lets invest in and create a rational healthcare system. We can no longer have a system in which 15 percent of our population does not have access. We have to stop ignoring evidence, whether in public health or individual care, and we have to start paying for what works and stop paying for care that has marginal or minimal benefits. We have to invest in our local communities and the diversity that is part of them. We need data and information and we need to invest in that. *(Please see Dr. Bill Hersh's article on Informatics — Ed.)* And finally, we need to start training a whole new generation of both public health and medical care providers. Thanks.

But in order to have a strong public health system we need to advocate for it in the political arena and we need to stay on message.

Mel Kohn, MD, MPH, Oregon State Epidemiologist

Mel Kohn, MD, MPH
Oregon State Epidemiologist

Thank you and good morning. It's really a pleasure to be here and I would like to thank *Oregon's Future* and the Oregon Public Health Association for inviting me to participate in this. And of course, what I want to say is both the same and different. I too was troubled by this word versus in the title of this panel because I think it really does set up a false choice. Both healthcare and public health are important tools. They complement each other and we really need them both to be strong. But as Bruce has alluded to, you know that while not opposed to one another, it is revealing to compare the budgets for these two activities.

The overwhelming part of our budget that is supposed to get us to health is spent on healthcare. And that leaves public heath as the poor relation, having to cobble together whatever it can scrounge from a variety of sources, and that's a very difficult situation for us both in public health and for the communities that public health is trying to serve. The history really does make the case for investing in public health. Bruce quoted this 30-year advancement in life span since 1900 and that's true but if you look at it closely, fully 25 years of it is due to advances in public health not in healthcare. When you look at that, we have to ask the question, "Why aren't we investing in public health in a way that is commensurate with its potential to improve health?" Well, any time you talk about money and investing money, and I'm glad I am sitting next to Representative Kruse here, it becomes ultimately a political question and so public health is political. We need to wade into this water in a big way.

Politics, in my view, is fundamentally about both public relations and advocacy. And frankly, we have not been nearly as effective in advocating for public health as we might be. We really have not done a good job of making ourselves visible and building public support for what we do. One of the keys to success for advocacy is to stay focused on a clear message, to 'stay on message' as they say. Frankly, in public health, we have had trouble staying on message. And that is because public health touches some very fundamental values that we hold: values about sexuality, about personal behavior

and choices, about personal responsibility, about poverty and I am sure you can name many others. They are really hot-button issues in a variety of ways. In the political world it is really easy for the controversies around these values to completely derail us and pull us from our primary message, which needs to be health and getting to health. Our task in this realm is to stay on message and talk about health. Push that to the forefront.

Now another major reason we have trouble staying on message is that we don't speak with a unified voice about who we are. We frankly, have confused public health with the role of safety net. Public health is seen by some as providing care for poor people. We become distracted by the safety net problem from our primary mission of promoting conditions in communities that keep people healthy. That is really a fulltime job and a unique niche. If we don't do it nobody is going to do it for us. So don't get me wrong, I am in favor of full access to healthcare, I think that is a very worthy cause, but don't confuse public health with access to healthcare.

So to recap, I want to say we need both a strong healthcare and public-health system. But in order to have a strong public health system we need to advocate for it in the political arena and we need to stay on message.

Representative Jeff Kruse
House District 7, Roseburg, Oregon

Interesting, eight healthcare professionals sitting at the table and a farmer. Our real problem is not about access to healthcare it's about having appropriate access to healthcare. If you're sick enough, you can go to the hospital and you will be taken care of. But that is not where we want healthcare to be. That's one of the things the Oregon Health Plan is supposed to help us deal with—is getting healthcare delivered in places other than emergency rooms. We have had a real struggle with trying to develop safety nets and get the baseline services. Someone mentioned earlier that since the first session ended 40,000 people have dropped off the Oregon Health plan. That's not true. They dropped off before the session and during the session. Most of them dropped off because they chose not to pay premiums when they were healthy. You know there are some cultural things that come into play here. From a political perspective for someone to say, "I am not going to pay $6 a month for healthcare," when the taxpayers are paying significantly more: That doesn't play very well. Yes, I am trying put out some fodder for questions here, and I think I am doing a good job of it.

I have been chairing the Health and Humans Services Committee in the Oregon House for the last six years. I have been heavily involved in the health plan and trying to save it. The one thing we attempted to do in the last session is change the discussion form focusing just on Medicaid to focusing on the whole healthcare system. Dr. Goldberg is going to be a big part of that in the future. We created a new commission that will come into being in January. That is going to be their mission. We need to change the discussion. It isn't about the public sector, -it isn't about the private sector, it's about how we get everyone on the same page. We are on the front end of that and we have reason to be encouraged in the future.

Keith Martin, MD
Chief Medical Officer, Legacy Health System

I am delighted to be here this morning. Unlike the other speakers, I was not angered or puzzled by this question. And I think that is a sign of my age. More and more I get to say things like, "That's déjà vu all over again." When I was an epidemic intelligence service officer working for the CDC in Los Angeles 30 years ago, this was the exact debate that went on. So why is it that the themes have not changed? The topics have changed and some of the tools have changed. What I see is that there is a greater overlap between the acute-care healthcare system and the public health system but the tensions are still there. The missions of most hospital systems include the improvement of the health of the community. That is certainly the core part of the mission of the heathcare system that I work for. As you heard Dr. Goldberg talk about, we use tools that were not conceived of 30 years ago. We talk about population health. We talk about access in ways that we never contemplated at that time. But there are some differences.

In this country, it seems increasingly important that we begin to make rational decisions based on the interest of society rather than special interests, and that these decisions be evidence based.

Keith Marton, MD
Chief Medical Officer
Legacy Health System

Let me start by commenting on the comparative budgets of the different parts of the healthcare systems. Those are partly illusory because many parts of acute care are called upon to provide public health. They do so by cross subsidizing those activities with the things that are reimbursed at higher rates. And that's part of the perversity of the reimbursement system. At Legacy we have quadrupled the number of public health physicians and nonpublic healthcare providers in order to maintain access in certain parts of the community. We find ourselves engaging in activities that we know are right and correct, but every time we do them they reduce our ability to generate the income in order to stay afloat. By that, I mean that every time we use a cholesterol

agent in one of our clinics, we reduce the likelihood that we will see a patient that has a highly reimbursable coronary artery surgery in our system. It's terrible to even have to talk that way. As a public health physician I hate doing that, but as an administrator of a healthcare system, I like our heart-surgery program to stay very active and vigorous because I know it helps to subsidize our nurse-midwife clinic in NE Portland.

I also see that part of the things we are mandated by legislation to do are often subject to debates and return on investment or evidence-based dialogues that I think we engage in more and more in the acute hospital system. For example, we now do hearing screening on every newborn that is born in the hospital system. I have yet to see evidence that this makes a difference, and it is a very costly undertaking that takes away resources from other things that do make a difference such as immunization, prenatal care, hypertension screening and treatment. So what I call for is a greater dialogue and a greater overlap between the acute care system and the public health system. In this country, it seems increasingly important that we begin to make rational decisions based on the interest of society rather than special interests, and that these decisions be evidence based. We are going to have to continue to ration healthcare, we have done that for years. One of the other quotes that have always stuck in my mind about the healthcare system is that, "We've been given an unlimited budget and we still mange to exceed it." And we are going to keep doing it as long as we generate our income through the high technology end of life care that is the most heavily reimbursed part of what we do.

David Mason, MD

Senior Vice President, Clinical Development & Regulatory Affairs, AVI BioPharma

Good morning. I feel like the odd person out and everyone here is deliberating the politics of healthcare. I work in the world of biotech business and it's been 20 years since I was a practicing public health physician in a community of health workers in a mill town in North Carolina. I have spent the last 20 years thinking about what I do now, which is to develop new drugs for difficult situations. What is biotech? The term originally referred to products that were made in cells. Either bacterial cells or mammalian cells, such as insulin. People now define it more broadly as any company that is using the tools of modern molecular biology. We have gotten these tools from the Human Genome Project. We are using them to develop drugs and diagnostics and we are discovering what it is about our bodies that really determines us. What we in biotech think about every day is more about individuals than about public health issues. In fact, take the Human Genome Project itself,what could be a better example of a focus on the individual? You have heard terms like designer drugs, not the illegal kind, but drugs that specifically focus on an individual's needs as determined by a gene test. This is a little bit naïve, however, I would say that some of the things that we accomplished, do affect public health problems.

Look at what we have done with HIV. Modern vaccines—many of these solutions are being driven by the biotech industry. In addition, a lot of the people on the panel and in this audience are representing people who are disenfranchised. People who are poor or who do not speak English. Biotech spends a lot of time developing drugs for diseases that affect less than 200,000 people. You wouldn't say that affects public health unless you have a child or a family member with polycistic kidney disease which is one of the diseases that we are working in. Another theme here is that, in fact, our society has many concerns now about quality of life and the rights of individuals to determine what we do. So for me, I have to separate individual rights and needs from the public health at large.

On the investment side, biotech is funded by the government. In Oregon you see a lot in the way of tax subsidies, relocation support, we do have some support from National Institute of Health grants and small business loans, but these are a fraction of the budget. By in large, the model for us is that money comes from private and public investments sectors. In a way we have become part of the new casino that represents the modern stock market and investors expect results. Our R and D is inherently expensive, our production is expensive, and our raw materials expensive. We are making drugs based upon DNA and its not cheap.

What do we contribute to society? I think that scientific advancement does

impact public health. The Human Genome Project will help us understand a lot more about health. I think new drugs will be a lot more specific and they will be safer. We will be able to treat diseases like cancer. Our company AVI discovered a drug for West Nile Virus and SARS, by the way. The West Nile Project went from discovering the product to treating patients in nine months. I think that is a world record. Is biotech investment worth it? I am sitting here as a taxpayer, consumer, parent and a public health physician wanting to know the answers to these questions too.

Mr. Holtz, Moderator: One question I would like to throw back at the panel is about how we grapple with this whole divide between a population viewpoint and an individual viewpoint. Because when someone goes to a healthcare provider, a service, something, is done for you. Whereas, in population or prevention of course, you don't see which individuals benefit. You know that clean water is good for you, but you don't know that you did not get sick that day because of the work that had gone on before. So, are there ways that the general public could have a better understanding to get beyond this natural tendency for people to pay for individual remedies, and this hurdle to understand the value to individuals of prevention? Who wants to jump at that one?

Dr. Castañares: Well, I'll take a crack at it. Let's use food safety as an example. There are good data (Dr. Kohn can probably reflect best on this) with respect to health risks and food safety when it comes to meats that aren't properly processed. The number of people sickened every year can be translated into, say, lost productivity if you want to quote dollars and cents. So you can make a business case for the kinds of measures that prevent such illness and morbidity. When such business cases are thoughtfully made, it really helps to drive the policy debates around investment in health care and public health interventions.

Dr. Marton: I think that our society is one that is based on the value of the individual. It's part of the way we think of things. I don't think we can ignore that, but at the same time, I think society does have to make decisions based on the value of an intervention on the population. So how do we deal with those two different conflicts? I think one part is continued education about how dollars should be spent. The second, is to have policies in place that enable us to make these decisions in the face of this conflict between the importance of the individual and many individuals. We have seen that when we have had to weigh whether to give a very expensive organ transplant or use the same number of dollars to immunize thousands. I think the other part is that a health system cannot be one-size-fits all. I think it has to enable people to exercise some choice, but that does not mean that society has to spend dollars for every individual's desire.

People talk about a holistic approach and yet our policy and our budgeting is far from holisitc.

Andrew Holtz, MPH

Mr. Holtz: To follow up on that, and maybe Representative Kruse, you could address this. How do we capture the savings? We often hear, "If we do this we will prevent X number of cases of this or that and that will save society money," and yet there is no way to bank those savings. One example I often hear about is if you do drug-abuse prevention or treatment that will reduce the load in our criminal-justice system. But the healthcare or the public health system does not get a check from the prison system for every inmate that they prevent from coming back. People talk about a holistic approach and yet our policy and our budgeting is far from holistic.

Representative Kruse: We have reached the point now that we are actually able to measure, with some validity, things that don't happen. This is a new dynamic that is clearly helpful and you're right: If we are able intervene with people the first time they interact with the law, and we know that 90 percent of people in prison have drug and alcohol issues, and we redirect them, then they don't show in the system. But you know we are talking limited dollars, and to break down the silos of funding at the state level is a daunting task. We can identify how much money we can save the Department of Corrections by doing X program, but to find the political will to divert the dollars, well you know, it's just not going to happen in the short term.

The fact that we are able to measure these things is new, and to a large degree, politicians don't believe it because it is a model and not hard numbers. Politicians for the most part expect immediate results from their actions. Which is why we have had such a hard time over the course of my time in the legislature, trying to move toward preventative programs. Because it is awfully hard to get advocacy for something that is going to have results 10 years from now, or especially 20 years from now. As a politician I am running again in two years and I want to show something for what I have done, and it doesn't equate. I do believe, however, that it is a dynamic that is in the process of changing.

Dr. Goldberg: Yes, I think it's a failed paradigm to think about healthcare as being about whether or not it's going to save money. We have to change the equation about how and why we invest in public health. We invest in public health because it actually does some societal good, not because it saves us money. I think we need to continue to look at, and

be realistic about the financing, but I think we have to change the public values we use to look at this.

Dr. Cave: Well, you can't separate public health from clinical medicine, at least the best environment is the one that does not. The one I am most familiar with is Kaiser. I am sure Keith (Marton) can talk about Legacy; but informatics is essential to link these two entities, whereas you take what public health shows for high-risk individuals and you insert that into the informatics, so that on a patient-by-patient basis, hopefully expanding that to an entire state, at one point, we'll be able to see when a patient shows up in the office and they are at high risk for A B and C, we know automatically we should do X Y and Z. When we get that, we are getting the best of all put together, and you can't isolate how much of this was public health money and how much of this was clinical care money. It all becomes well integrated. Those health plans that use information this way can determine how much it will cost them the year before for flu-based admissions and how much they saved the following year. Hopefully, we'd see an improvement in access and hopefully, the public sector can learn from the private sector in these areas. *(In this issue of* **Oregon's Future** *please see Dr. William Hersh's article on informatics —Ed.)*

Dr. Marton: This question about incarceration and treatment for those with a drug-abuse problems, I think is a great illustration of what the optimistic side of me says we need to value—patience and persistence. I say that, because about 11 years ago I was one of the commissioners for health in the city and county of San Francisco. We heard these statistics,we heard we could spend a dollar on drug treatment or we could spend $7 on incarcerating the offender. We were like everyone else. We were unable to do anything about that at the time, we argued, we gnashed our teeth. Last year the state of California did pass a law diverting people from the criminal justice system to the treatment system. It took that much time for those kinds of statistics to become real to people in such a way that they acted upon them.

Dr. Kohn: Yes, I would like to say that keeping the emphasis on public health and health is something we are all after and is really important. That is not to say that we completely ignore the finances, obviously we have to deal with reality, but again with patience and persistence, to use Keith's (Marton) phrase.

Mr. Holtz: In terms of getting toward the goal of health we are trying to move the vocabulary from saying how much are we spending on healthcare to how much health are we buying? What gets us the greatest benefit for health? Is it something that we realistically do—how long does it take? Do we have the information or is it just a matter of saying we need a vastly greater investment in evidence-based medicine, outcomes and research? What do these prevention efforts or other measures produce in terms of health?

Dr. Goldberg: I think we have to be careful to not create a medical system where these breakthroughs widen the gap between the haves and the have-nots. We have to create a healthcare system where the benefits are for everybody and where all this does not eclipse our basic sense of values and our sense of community and fairness, equity and justice. I think these are the issues we need to concentrate on.

Dr. Kohn: You know we live in an imperfect world, and we have to make choices and take action before all the data are in. That doesn't mean you don't need any data or you should always jump before you consider what you options are, but I think that there is a lot that we already know how to do very well. We know immunizations prevent many serious childhood diseases, and yet we are not able to get all of our kids immunized in this state. We know how to deliver effective tobacco control, and we still have a long way to go in this state. I guess the glass is half full or half empty depending on how you look at it. There is a lot we know how to do, the outcomes are well proven, and there is good data to support them. We need to just get on the stick and just do them.

Ms. Dodson: I think we also need to have some compassion, that not all the services we are talking about are for all the people. We have some vulnerable populations. We as a society have a responsibility to these populations, just as we do for the whole population. When we look at cost we are not just looking at the cost for just one hearing screening. We are looking at the cost to one individual. What is our social justice responsibility to that individual? We need to look at the outliers as well as those in the middle of the continuum.

Audience Question: How can public health decrease disparities?

Dr. Castañares: I would like to reframe that question. How might a different paradigm or a different way of thinking reduce health disparities—a paradigm in which public health and elements of clinical care are merged and redefined, together?

I'd like to use a personal example: my father, whom I am about to go visit today. He's going to be 97 years old in January, and he was just put on a new preventative drug, Lipitor, for his arteriosclerotic cerebral vascular disease. Use of these statin drugs for prevention is becoming more and more widespread… a new super pill combining a statin with aspirin and something else is due to come out soon, with the idea that most adults will need to take one every day. These are meant as preventive measures for whole populations, and the argument for them can certainly be made although I would take issue with it.

Two things come to mind, for me. One is the matter of disparities, which was your question. Not everyone is going

to be able to afford that super pill—in fact, not everyone can afford that statin my father has been put on. So there are immediate disparities in how we deliver the care—and even in how we view preventive interventions based on population statistics, epidemiology, and evidence-based medicine (How many 97-year olds on these drugs have we studied?). The second issue is the matter of priorities. We have not thought, as a society, about the 97-year old man and how far we want to go, how much we want to spend and expend, what expectations we have. I love my father and I'd like to have him with us for longer yet. But we've had him for almost 97 years, and I think we have to take a deep breath and look at this again. This is part of the public health thinking that has been alluded to at several points today. What is it that we aim to achieve in someone at this advanced age? We need to take a look, as a society, at the end point. We will all die, right? We will all die sometime. So if we prevent this or that condition that in the past has led to death, we are postponing death…sometimes with great compassion and foresight, but sometimes not—sometimes not prudently from an economic point of view. We have no system of thinking today that leads us or even allows us to back off at some point. And that is why my 97-year old father was put on Lipitor this week. We have no way of thinking that would say: It's time to apply our resources elsewhere, for some different expectations.

I know that this is controversial. I'll throw out another controversial scenario—more controversial still—and that is of the fragile, premature, very low birth weight newborn. Until we make decisions about such issues, we will have problems with unleashing the new tests, the new drugs, the new interventions—and the disparities these inevitably lead to, because there will be huge problems of affordability with the next new drug or intervention or surgical technique.

There will be problems of disparities until we think differently about the public's health—what we want in outcomes and health status of populations.

We have not thought, as a society, about the 97-year-old man and how far we want to go, how much we want to spend and expend, what expectations we have.

Tina Castañares, MD

Dr. Kohn: I think that we are still learning about what we should be doing to address disparities. When Healthy People 2010, *(A national health agenda, promoted by the USHHS to increase quality and years of life, and eliminate health disparities—Ed)* the federal government's set of goals for health has the goal for 0 disparities. That was a very ambitious goal. I think we are still learning how to do that. I don't have an easy answer, except to say that the place you start is by working with those communities that are disproportionately affected by whatever health problem that you are focusing on. And talking with that community, and even defining what that community is, sometimes can be difficult; but talking and being there with that community and trying to figure out strategies that work. It is not a process that has immediate return on investment. It takes a long time, and frankly there is a lot of history that has to be overcome, because many of the communities that we are dealing with have been marginalized by a number of forces in our society for a very long time. That is not something that is going to change overnight just because we in public health decide we want 0 disparities. Of course the societal forces that come to bear on these health outcomes are complicated. You know you push on one place and where you have pushed in pokes out someplace else unexpectedly. I think we have a ways to go, certainly, but we need to start addressing this.

Audience Question: Dr. Marton, you commented on the benefits of preventative population-based interventions but somewhat dismissed the newborn hearing-screening effort—a preventive population-based method—Could you please comment on that?

Dr. Marton: Sure. I'd been surprised if that didn't generate a question. What I am really getting at is that we all know and agree that prevention limits problems when it's supplied properly, and when it works it is better than intervention at a later time. In many ways that has led us to believe, almost wholesale, that any prevention is good, and yet I think there is a lot of evidence out there, and this is the core issue—the evidence—that there has to be evidence to support the value of a particular prevention.

A lot of things in terms of screening are thought of as well-meaning and designed to prevent or detect disease at an early stage—the wholesale development of whole-body scanning around the United States is an example of misguided screening that detects more problems than it prevents. And with the hearing screening, what I am saying is that first you have to have data that shows that the hearing tests really do detect hearing problems. Well more than 90 percent of the hearing problems that we have detected in our system were not really hearing problems. It has to do with the inaccuracy of the technology, and so we subjected parents to worry and the fear that they had a hearing-impaired baby when they didn't. They had to have follow- up testing, they had to go through anxiety and waiting. Well in the scheme of things, maybe that worry is not that

great compared to other kinds of worries but was it necessary? And once we found the hearing impairment, was there evidence to show that intervening at that point as opposed to later on down the road affected the child's ability to speak or to learn to interact? Well we don't have any data for that yet either, and so to me, it's a big open question, but I would apply those same concepts to many other things.

We are very enamored with screening and early detection and early intervention. When they are based on things like: The early detection of hypertension, clearly a benefit; early detection of breast cancer, clearly a benefit; early detection of cervical cancer, clearly a benefit; early detection of hypercholesterolaemia, not so clear. You can intervene very effectively now at any point in someone's life, although I would not intervene with a 97-year-old man.

Audience Comment: I'd like to say for Dr. Marton's sake that there is, in fact, extremely good evidence that if hearing loss is detected in a child under the age of six months, the child will have a much better outcome than if it is not detected until the previously-screened age, which was typically about 2 years old.

Audience Question: I just want to ask—how do we learn to say no to healthcare without saying no to health? We have had some examples from the oldest of the old to newborn screening. By what specific means do we learn to say no?

Dr. Cave: The costs of medications are directly related to the costs it takes to take care of people. We have medications that do a great job that have been around for 20 years and are as effective as the ones coming out now. To say no means educating every single person you can about direct-to-consumer advertising on television. People need to know that they don't need the dollar pill and that they can take a two-cent pill. That other 98 cents can take care of a lot of other people and provide a lot of other resources.

That is one of about 1000 ways, it is something you can do now. AARP has taken the lead on that and the seniors are large consumers of healthcare services. So we need to partner with our patients and that analogy can be used in all the other different subsets as well, whether it's a procedure you need or medication or hospitalization versus outpatient procedure.

We have medications that do a great job that have been around for 20 years and are as effective as the ones coming out now.

Colin Cave, MD, President Oregon Medical Association

Dr. Castañares: One can talk about individuals, but I'm going to talk about this collectively. I think a well-kept secret is that the priority-setting process of the Oregon Health Plan worked. Effectively, we said that the trade-offs (a more selective benefit package, but more people covered) were worth it. That's the thing that's lacking today: clear trade-offs that are meaningful to people. I think as a society we would be willing to say yes to such trade-offs. I personally, and my family, would forego a certain array of services or coverage, if our foregoing them meant *x*, meant more access for more people, meant more money being put into prevention, more resources put into public health initiatives and services. If the trade-offs were clear, and the benefits of certain sacrifices assured, then I think we would all be willing to say *no* to certain things that we realize are less important.

Unfortunately, we've lost some of the force of that—of our own successful experiment here in Oregon. It hasn't yet been expanded to other areas, neither within our own state nor in a nation as a whole. If we could make our values explicit and create priorities that we say yes to, then make the trade-offs real and understandable to us as a public democracy, then we would have the ability and will to say, collectively, *no* when we should.

Dr. Kohn: I think as we talk about redesigning our healthcare financing structure, we need to look at this policy question and our goals. Now, we know for chronic disease care that 95 percent of what determines that person's health, regarding that person's chronic disease, occurs outside of the providers' office, yet we have no really good way of reimbursing that and paying for that. We need to look for opportunities to include funding for public health services as the system is changing.

Mr. Holtz: Donalda, I wonder if you could follow up on that? In your opening chat you talked about the roll of public-health nurses being out in the community and the roll of allied health professionals. What can be accomplished outside what we think of as the silos of reimbursement that are easy to see?

Ms. Dodson: Well I'll just follow up on Mel's comment. In communities with public health nursing important issues are dealt with. For example, breastfeeding promotion is one of the primary ways to prevent obesity, so helping to mobilize communities around that type of activity is important. Public health nurses and other allied health professionals in the community, working with families, help people understand they don't need to call the physician to get an antibiotic every time a child has a runny nose. Because of this, we have seen an increase in awareness that overuse of antibiotics is not a good thing. When you have no messengers, when you have no town criers, you have nobody to get these messages out. I think that is the issue that plagues public

health. We are so funding driven in a way that allows $1 for services and we are told what to spend that dollar on sowe can't have the town criers.

Mr. Holtz: Do promotoras *(people trained to get out certain public health messages—Ed)* need to be in every community so that people start changing how they think of health, so that health is not seen as for the wealthy or more politically connected? How can we put a broader definition into people's daily experience of what health means and who is the health professional they have the most experience with?

Ms. Dodson: I think one of the biggest challenges we have had over time is that public education component. Because the public education message gets out to everybody, its not targeted for the low-income individual. The message is: stop smoking and you will live longer lives, breast feed and your baby will be healthier, take folic acid if you are pregnant, don't over use antibiotics. We promote core messages to the general population. But people don't even know they are getting a public-health message because it is embedded in the communication they get from the paper, that they hear on the radio, that you see in the pamphlet in your physician's office or at the community clinic. These are preventive messages that are not focused on specific populations.

Audience Question: One of my concerns is the issue of priorities and dissemination of information regarding public health and healthcare. Could you address how you are determining priorities? How can dialogue be greater with the public so that they can have broader perspective on addressing the issues we are discussing today?

Dr. Marton: Well, I suspect each one of us could comment on how our organizations or constituencies prioritize. I will speak for Legacy Health System. We start with two things, one is our mission and the second is a strategic plan. The strategic plan is an attempt to look forward into the future, to understand what is going to happen in our society, and then to apply our mission to identifying strategic initiatives. We do that on an annual basis, although we have a major undertaking about every ten years to create a ten-year strategic plan. It's important because every time we make a decision we ask how does this fit with the mission of a not-for-profit-community-based organization? How do we weigh the various decisions that we have in front of us?

If we make purely financial decisions, for instance, we would populate every part of Portland with an MRI machine because these generate an incredible amount of revenue, but that doesn't fit with the mission. That's why we have programs in child-abuse detection. It's why we do have programs in prenatal care. It's why we maintain a program in adolescent psychiatry. Even though each one of these could not be viewed in a for-profit environment as a financial feasible activity, they are incredibly important in how we see ourselves and address the needs of the community. It's why we have grown our primary-care clinics in parts of Portland and the surrounding areas where other entities couldn't exist. I'll give you an example, In St. Helens, six years ago, Legacy did not have a clinical presence. Now we are almost the only healthcare presence in that community, because it hasn't been financially feasible for the individual practitioners to provide care in that area. But it is an important part of the healthcare community that we serve. It's a blend of trying to make decisions based on what we think will work best in terms of advancing the mission, and how to make the overall balance of activities financially feasible.

Dr. Goldberg: A lot of the discussion has been about these issues from the perspective of disciplines or professional or of institutions. I think you were alluding to what I think is the appropriate priority, how to change this all back to what are the priorities of communities and the individuals that live in them?

Dr. Mason: I am here representing a small community in the state of Oregon, the biotech companies that are struggling to just stay in business, and you are saying that your community and a larger community wants to know more about us. I am aware that what most people hear about biotech is how much it threatens their health, -in other words, genetic engineered crops. You don't hear much about the good stuff. I think the Biotechnology Industry Association and the Pharmaceutical Research Manufacturers Association have done an extremely poor job of getting across the message of value to all communities. What I hear you saying is that we are willing to discuss the value of medicines. We know how much they cost, but we don't know much about the value.

I am very interested that you want more information. I don't know how it happens. I think there is a lot more not known about what we can offer than what we do offer. I so appreciated your comments very much.

Dr. Castañares: One of the organizations I work with is La Clinica del Cariño. We and other agencies in the Gorge, make high use of community-health workers for engaging the community. This allows us to have continuing and fresh dialogue with community members. I think that nothing has worked half as well as employing and listening to our community health workers. Most recently, we conducted door-to-door, one-to-one surveys and conversations with community members, with the support of the Northwest Health Foundation. I think that's what democracy is supposed to be about -finding ways to do that. I urge everyone here to utilize community health workers as an ideal and unique way to help institutions, organizations and groups of healthcare professional to engage in meaningful dialogue and program design with our communities.

Audience Question: What are the cultural imperatives, policy-wise, that we need to develop to make sure that our efforts are not in vain?

Ms. Dodson: I think we need to talk to individuals and their communities. There needs to be a way for such communities to express themselves, and someone who is listening. We need to work with these communities not do something to them.

Dr. Castañares: I'd just like to make one other comment about disparities. I happened to visit Central City Concern recently, and met with one of their mentors who is in the chemical dependency program—someone in recovery, an African-American woman, single mom, who is clean and straight right now. And I dare say she has more applicable experience than most of us when it comes to helping other people with their healthcare needs. I mention this example because we need to provide culturally appropriate healthcare—an interest that is unfortunately still lacking in a lot of our institutions. We have to be truly interested in other people's cultures, and not regard them as a problem, not regard this as "p.c.," not regard the patients as non-compliant. Rather, we need to start with the strengths of each culture…this goes to the heart of engaging and listening to our communities.

Audience Comment by Mary Lou Hennrich, Community Health Partnership: We did have a model in Oregon that did work partially and had the potential to work even greater and that was the prioritization of healthcare services. Donalda (Dodson) was on that first Health Services Commission, so was Tina Castañares, and Michael Garland in Oregon Health Decisions. I mean there has been a whole lot of process that has gone on. Part of my reading of the tealeaves is that we did start losing our persistence and continuing efforts when the going got tough. It frustrates me when we keep talking about prevention, things that we have to prove the outcomes for, when all the time we have these medical care interventions that have not been proven, but are just based on strongly-held beliefs and a lot of special interest that keep them going. I do think we need to step back and look at the fact that we did a really outstanding job with prioritizing for OHP. Inadequate, not totally workable in many ways, but I think we have to go back and revisit this approach. We are spending too much money right now and not putting it into some of the population-based and preventive programs.

Mr. Holtz: We have lot more to discuss. This is just a point along the way. I want thank everyone who came this morning and thank the panelists who shared their time and perspectives on a question that was provocative, and perhaps unfair, but definitely provoked good discussion. Thank you very much.