Layperson to Layperson

An Introduction to the Public Health Update

by Jay Hutchins

While researching a forum we always come across more interesting information than we have room to print. One story we decided to include here comes from the *Wall Street Journal*. In the February 17, 2004 edition we learned that the National Institute of Health (NIH) has recruited 600 doctors to educate their associates about hypertension guidelines. Through this maneuver the NIH intends to counter the message carried by 90,000 pharmaceutical reps who encourage doctors to prescribe new expensive drugs for high blood pressure; drugs that, for many patients, may be no more effective than much cheaper diuretics. Such an initiative targets the marketing of expensive "me too" drugs as a health problem that requires a public health style intervention. This example of the nearly perverse complexity of our society demonstrates the cross-purposes and tensions that naturally evolve in our culture's free market, two party democracy.

We based this update of our Fall 2002 forum on the *Oregon's Future* Public Panel Discussion held at the Oregon Public Health Association's (OPHA) 2003 convention. The edited transcript of the panel, Public Health vs. Healthcare, focuses on population health issues, the economics and ethics of clinical care's free market orientation, as well as how these systems interact to create not only obvious and bizarre conflicts of interest, but also opportunities for change.

One source of information we used in our research on population health is Ichiro Kawachi's and Bruce Kennedy's *The Health of Nations*. Kawachi and Kennedy correlate income gap with the overall health of populations around the world and within regions of the U.S. They point out that in the U.S. the income gap is much higher than in other countries with modern economies, and that our mortality rate is worse than 26 of these nations. Our infant mortality rate appears to be the culprit; actuarial tables indicate that our adult mortality rate, at the age of 50, is one of the best in the world.

Funding imbalances between public health and clinical care is an issue most public health officials come back to again and again. The disparities worsened by these imbalances are a major concern to all our panelists. In her presentation at the conference, Dr. Tina Castañares, poignantly addresses the ethical and emotional issue of prioritizing highly reimbursable care for those near the end of life.

Even though emerging research indicates that the prenatal environment greatly sets the stage for health throughout life, prenatal care is not highly reimbursable and generates little revenue to support hospitals and clinics. At the panel discussion, Dr. Keith Marton, Chief Medical Officer at Legacy Health System, reveals the challenge he faces while trying to fund Legacy's obligations to prenatal care with revenue generated by profitable, highly reimbursable surgical interventions for heart disease, a condition which he has dedicated himself to preventing. Dr. Marton calls for a greater dialogue and a greater overlap between acute-care and the public-health system.

Over the last two years, inefficiencies in the healthcare industry have helped create a third of the new jobs in our economy. This fact helped us decide on one topic in this update for a stand-alone article. Many Oregonians are unaware that their medical information is stored in discrete caches, not always available to clinicians who may need it, and that who actually owns such information is not completely certain. People I have spoken with are surprised to find out that records of their visits to emergency rooms do not automatically end up in their primary care physician's files—even when both sets of information are in the same building complex.

Within public health, officials refer to 'silos' of information that reside in discrete areas of cyberspace, commonly available only to the agencies or institutions that create them.

The study of the way information is electronically gathered, stored, and accessed is known as informatics. Dr. William Hersh, Professor and Chair of the Department of Medical Informatics and Clinical Epidemiology at OHSU, tackles this issue for our readers. Drugs, emerging diseases, bio-terrorism, medical errors, access to health care, and all the other topics discussed at the Panel depend on solutions that make better use of information technology. Dr. Hersh explores the political, logistical, and economic issues around creating a standard protocol for a shared electronic health record that also links to standard evidence-based practices.

It is hard not to speculate that such a system could give Oregonians one of the clear benefits of a single-payer healthcare system—efficiency—without the political problems. However, seeing is believing. The resistance of some doctors to write computerized prescriptions is one of many hurdles that will have to be overcome. An experienced health journalist I spoke with believes there is broad agreement that medicine has to pull itself out of its 19th century habits, but the transformation is likely to be more expensive and wrenching than often portrayed.

At the panel discussion, Representative Jeff Kruse (now running for the Oregon Senate) acknowledges the obstacles to making a major shift in the way we look at funding for public health. He explains that we have the ability to predict positive outcomes for prevention and he uses the example of drug rehabilitation programs. He points out that we

can compare these programs to the cost of alternatives such as simply incarcerating drug offenders. He then discusses the politics of getting reelected when the benefits of sound public health legislation are only realized far into the future, or when we won't actually see what we can get for our money because something really bad never happens.

A topical issue, methodically covered by Dr. Colin Cave, President of the Oregon Medical Association, is the impact of our medical tort system on the number of physicians in Oregon. This spring Congress once again failed to address this issue. Oregonians will probably vote on a ballot initiative that addresses this issue in November. Dr. Cave argues that Oregon should place caps for malpractice awards on non-economic damages because this will improve access to healthcare. He also addresses the topic of education and the costs of care including the benefits of informing people about "me to drugs" and procedures whose effectiveness is not evidence-based.

The subjects of malpractice and evidence-based medicine prompted us to look at medical errors, considered a major public health issue as well as a crisis in clinical care. I have reported on this subject in *Malpractice Crisis: Some Facts and Concepts*. Somehow, the normal operating procedure of the healthcare industry has created an epidemic of medical errors and evidence suggests that the tort system may not be the solution.

Meanwhile, the Oregon Patient Safety Commission has created a first-in-the-nation program, perhaps comparable in significance to our Death with Dignity Act, (which has improved pain management in end-of-life and hospice care in Oregon). The Commission is charged with setting up a voluntary adverse events reporting system protected from the civil courts.

In the panel discussion Dr. Bruce Goldberg, Administrator of Oregon Health Policy & Research, emphasizes the importance of restructuring the way we manage medical information. He also encourages everyone to look at the humanitarian benefits of public health interventions and not just the economic ones. Dr. David Mason points out that the biomedical industry has done important work in combating emerging diseases such as SARS and HIV, but that biotech companies have to make money to invent drugs that protect the public health.

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Donalda Dodson compassionately makes her case for more public funding of public health nurses and what Andrew Holtz refers to as promotoras, people who spread the word about such subjects as hypertension drugs, SARS, HIV, or that breast feeding reduces obesity in children. Through his questions, Andrew Holtz highlights the fact that all socio-economic groups benefit from public health messages and initiatives, yet most middle and upper class Americans think primarily of their personal doctor when they think about their health. Dr. Mel Kohn, our state epidemiologist, urges the public health community to keep focused on promoting conditions in communities that keep people healthy and what can be accomplished with current funding within the scope of public health's traditional mission.

One indisputable and organizing fact emerged from our research for this issue: Patients and physicians, administrators, researchers, and public health officials all need easier access to accurate information and the technology that will allow this to happen. With this in mind we introduce this update issue.

We would like to thank all of the panelists and authors who participated in the forum including Andrew Holtz who volunteered his time to moderate the public panel discussion. We also are grateful to the Oregon Public Health Association for hosting the *Oregon's Future* Panel on Public Health vs. Healthcare—a title that seemed to infuriate many of our public health panelists. Please see our website, www.oregonsfuture.org , for further information on issues such as the costs of prescription drugs, obesity, tobacco, and evidence-based procedures, the effect of major public health initiatives, genetic privacy issues, as well as a discussion by Dr. Donald Austin of OHSU on the use of the scientific method to help officials make public health interventions.

Is Canada's Grass Greener?

As we go to print in the aftermath of Measure 30, the Oregon Health Plan, once a national example of how to provide care to the uninsured, has been gutted of both funds and patients, many of whom have dropped off its rolls rather than pay a fee for reduced services. At the same time, the Canadians, whose universal healthcare system uses only about 10 percent of their GDP (compared to our 15 percent), are set to reform their system with an injection of cash and some new rules. Canadians have finally become fed up with waiting times for surgical and clinical procedures, and those who wish to privatize Canada's system are challenging the current liberal government. Most nations who have universal care also allow a privatized care system to compete for patients who wish to pay extra for more services and better accommodations. One concern for Canadians is that approximately a billion dollars (Canadian) leaves Canada each year for medical services in the United States.

Another newsworthy series of events is taking place in the state of Maine, which is about to be the first state to implement a universal healthcare system. In other states, business leaders' concerns about remaining competitive with foreign companies have made them more open to our government resolving their healthcare crises. Jobs are moving to Canada and competing with businesses here. One of the reasons is that Canada's universal healthcare system makes it cheaper to operate a business.

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