Health System Transformation Lecture
The Healthiest Nation
First Panelist—Dr. Richard Saltman

This podcast is presented by the Centers for Disease Control and Prevention. CDC—safer, healthier people.

Thank you so much for a wonderful talk, tremendous insight—provocative, but also inspirational. We now have a few minutes for discussants, and let me introduce them. First is Professor Richard Saltman, who is an expert in comparative health systems. He is a Professor here at the Rollins School of Public Health in Health Policy and Management; he's a cofounder of the European Observatory on Healthcare Systems, an international partnership based in Brussels. He holds a Doctorate in Political Science from Stanford University and has published 15 books, and more than 100 articles on a wide variety of health policy topics, particularly on the structure and behavior of European Healthcare Systems. He work with—he works with many European ministries of health, as well as with WHO, the World Bank, and the OECD.

Our second discussant is a Senior Fellow with the Policy Institute here at Emory, Greg Marchildon. He is currently Canadian—he is currently Canada Research Chair in Public Policy and Economic History at the Johnson-Shoyama Graduate School of Public Policy at the University of Regina. He's also Director of the Saskatchewan Institute for Public Policy and a Senior Fellow at the School of Public Studies at Queens University. After obtaining his Ph.D. from the London School of Economics, he taught public policy, economics, and history at Johns Hopkins University School of Advanced International Studies. In 1994, he returned to Saskatchewan where he became Deputy Minister of Intergovernmental Affairs, and in 1966, Cabinet Secretary and Deputy Minister to the Premier. In 2001, he became the Executive Director of the Commission on the Future of Healthcare in Canada. Thank you for joining us for this discussion.

Thank you very much. On behalf of the Institute for Advanced Policy Solutions, I'm very grateful. I'd like to thank Dr. Gerberding, President Wagner, and Dr. Sanfilippo for initiating this series and beginning this dialog. I think we had an excellent initial discussion.

In terms, however, of how I approach this and the comments that I would make—the two cautionary perspectives, the two frames of reference that I bring to this, which Dr. Sanfilippo already mentioned, are those that raise crucial questions in terms of how you get there. The key word from the political science perspective is implementation. How do you implement? Those of you who have looked at the political science literature know that implementation is seen typically as the weak link in policy—in the policy framework. So, political science raises at least a yellow flag and says, "Wait a minute. How are you exactly going to—exactly how are you going to do this?"

And then, the European experience raises some very interesting questions about the process that's necessary to perform implementation, to begin to move in the direction that we would like to move in that Dr. Gerberding has set out as an objective. In terms of thinking about where we want to get, this is a rather summary chart, and if I can figure out how we get—no—no. Well, essentially it's a question as was apparent in the—in Dr. Gerberding's presentation, how you

move upstream, how you move inside curative care from acute to primary care and to primary healthcare, which is a much broader area than primary care. And then beyond that, how you move into zones of prevention in which there's health promotion, disease prevention, then there's various forms of social development, education, housing, nutrition, all of which impact on health status.

And then the whole question of work organization—this notion of a new paradigm which was put forward in 1994 in a book by two Canadian economists, Bob Evans—Morris Fairer, drawing on a whole wide range of research, suggests that the core framework for ill health has to do with dilemmas of status, has to do with being caught up in hierarchy, the dilemmas of uncertainty and lack of control. Sir Michael Marmot, some of you may know, a British epidemiologist on the Whitehall studies, served as a major source for thinking this way.

So, the objective is to try and move upstream. There's really two themes that are part of that process. One is inside the acute sector, moving from the—from inside the hospital walls toward primary care and primary healthcare. That's theme number one. And then there's theme number two, which is moving from acute to prevention or increasing prevention as a way to reduce the number of individuals who end up in the acute sector.

If we look at implementation in Europe, we can learn about its efforts to try and move in this direction in a number of different countries. I've just picked two in order—in part, to stay within time, but because I think they make the case directly. Sweden, 1972, passed a National Primary Care Act to structure primary healthcare centers for each municipality that would be responsible for the broad structure of healthcare, including preventive acts. 1990 they established—I should say (INAUDIBLE) Institute, the Population Health Institution—the Institute—Institution for Public Health - whose objective was to pursue the second theme—was to pursue more prevention and move the process in the Swedish system upstream. That institution was extremely well funded; it had a substantial amount of money. 2005—as part of our work with the observatory, we met with senior policymakers in all four of the Nordic countries to get a sense of where they thought they were and how well they thought they'd done—people in the ministry, in particular. They were, in Sweden in Fall of 2005, very unhappy with their primary care performance, and they were very unhappy with their progress towards prevention. If you do the math on the number of years, despite the funding, despite the support from the national government, despite the resources, they were not happy with their implementation.

Finland which is often seen as a model for the *Health for All* program for the World Health Organization, globally. Finland, 1973, passed its primary healthcare act, national legislation that obligated on a mandatory basis the restructuring of primary care as the central focus for the healthcare system. Through the 1990s, there was a major push on prevention. That's the second theme. So, they pursued, roughly in the same time period as the Swedes, the same two themes. In the meeting in 2005 with senior policymakers, same exact story. They are unhappy with their primary care, which is quite different than what the Swedes have for primary care. They are unhappy with their progress towards prevention in which they are similar to, but then there are differences as well. What does this suggest about the difficulties of implementation? One more point, and this is the kind of point where scientific research makes life difficult for policymakers. This is emerging work from Martin McKee, who's one of my colleagues on the European

Observatory, who's at the London School of Hygiene. Looking at the broad data, he now estimates that curative care is responsible for something close to 25 percent of health status, and not—and that's a two-and-a-half times increase over what had previously been thought as the contribution of curative care to health status and to change.

What does that suggest? It suggests that maybe we have to focus our attention equally on the curative care, on the secondary and tertiary hospital sector as a source of health status. That has not been the framework that the epidemiologists have laid out previously. This is obviously controversial work. There will be a lot of discussion.

Policy implications here. Systems, countries that have uniform public systems—publicly funded, publicly operated systems—they have a strong government role in terms of how that system behaves—have not been able to be very successful in terms of implementing strategy number one or strategy number two. What does that mean about the U.S.? How do we get there? How do we implement?

As President Wagner and Dr. Gerberding and Dr. Sanfilippo all said in a slightly different way—we have an atomized private healthcare system, we have a strong cultural aversion in our society to the notion of strong government intervening in healthcare. What does that mean about the likelihood, given our structural framework, about how we go about this?

And this is my last slide. What it suggests from a practical, pragmatic point of view is that we have to take a step back, look at our initial strategy, see whether it's possible to harness our own cultural framework, our own values, the core of what drives the U.S. system, which has to do with individuality, which has to do with private sector modes of operation, at least as much as public sector, and see how we do that, how we redesign the process rather than thinking that what has been implemented elsewhere might, in fact, provide the framework for implementation here.

So, I warned you, as a political scientist, I wasn't going to be bringing you happy news, but this would seem to be an assessment of both—from a political science perspective including the (INAUDIBLE) policy perspective about some of the ways that we might try to achieve what we hopefully will do. Thank you.