Health System Transformation Lecture
The Healthiest Nation
Question and Answer Session

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

We are running a few minutes behind, but certainly there's some time for questions and discussion. Let me again thank our two discussants and open the floor to questions that you might have.

QUESTION: Yes, I was just—I was just wondering on a global basis, we're all medically—I mean we're nations of medical illiteracy. In other words, if we were to ask people who aren't physicians here if they got belly pain, where their appendix is, they might not know that. A lot of them don't. We teach a course here with college students, 1,400 of them, in their Health course, and we ask them, "If you hit—fall and hit your head, what could you do just looking at the two pupils to know whether there might be an emergency?" And they've never learned that. Or, "What is a heart attack?" That's not learned. It's not considered important to teach in school. It's not considered important to teach in school interactions of drugs. But in the medical profession, there's a group of people in nursing and medicine who have that inside information. And I just wonder whether any aggressive effort at really instituting medical literacy might have some positive outcome. The other very interesting fact is that if you take the biggest killer - cigarette smoking - two percent of doctors smoke. Two percent of doctors smoke in this country. About 16–18 percent of the rest of the population does. So, there probably is some value in the medical/nursing education programs.

ANSWER: This could be a great topic for another lecture or another symposium - the whole issue of medical literacy - and I like to say science literacy, more generically. We've created this society of elites who have their own languages and their own technical knowledge, and we've created a society of citizens who have none of the above, and yet we expect our citizens to be able to take in that knowledge and do something helpful with it or to make use of it, and it's impossible. We struggle with that at CDC. I'm sure you struggle with that at Emory. Sometimes scientists really aren't the best communicators unless they're communicating with other scientists. So, how do you help translate the technical information into something that's accessible by people who don't have a professional degree in that area? And there're no easy answers, but one of the exciting things to me is the Internet, in particular 2.0. First of all, people can learn in a much more agile and fast manner than they ever could before. So, our tools to support knowledge acquisition and development are accelerating. The downside of that is there's no credentialing of the reliability of the information that they have access to, and we're kind of struggling with this at CDC, recognizing that while we still absolutely expect to be creating new knowledge, our bigger role might actually be in credentialing and facilitating the uptake of that information into ways that people can actually use. And that's why we developed the new Center of Health Marketing and the new National Center for Public Health Informatics and why we expect the integration of that with our National Center and Health Statistics to really be the leading edge of CDC in the future, in terms of really where the rubber hits the road. But we're a long way from there, and I think the science of that translation is an exciting area that needs a lot more investment.

Other questions? Yes?

QUESTION: I just want to ask the—am I loud? The—when you were discussing the case of Sweden and Finland and when they were making the decision in 1972 or 1973, they were satisfied with what they—what are the changes that they are making—they were making, but at the same time, they said they are not satisfied now. And in the United States, the same thing—they are not satisfied with the health, and even if you ask even developing countries, it will be the same. So, is it a question of perception or is it a question of objectivity?

ANSWER 1: Yeah, it's a very interesting question. And it revolves around, really, the difference between individuals who tend, in most countries, to be satisfied with their own individual care. There's variation between countries, but that's quite different than policymakers who are not concerned about clinical medical care, but they're concerned about moving populations upstream, in terms of both primary care and prevention, both for cost reasons, for health reasons, and in terms of the policymakers who are the ones who are not satisfied with the progress that's been made. In Sweden it's a standard gambit of the publicly operated system to go out and do questionnaires of the citizenry and say, "How happy are you with the healthcare system and would you be willing to pay higher taxes?"—this should be an interesting concept in the current presidential debate in the United States—"Are you willing to pay higher taxes to improve the healthcare system?" And the numbers always come back 85 percent say "yes." So, the individuals themselves, while they have their issues with the system, are basically happy. The problem is that it—they're talking about the curative medical side. They're not talking about the preventive side, and it's certainly a question of how you move that knowledge about what should be done in prevention into action as Dr. Gerberding was just saying. That is not something that is commonly assessed by the survey research people when they go out and talk to the citizenry.

ANSWER 2: I'm really fascinated by this idea of a health index and I really want to learn more about this, but, you know, we should be living in a world where people can't get elected if the health index is bad in their community in the same way you can't get elected if kids don't graduate from high school or there are potholes in the street. But we don't even have the most rudimentary tools to be able to provide that information in perspective to the citizenry who are making the decision.

ANSWER 3: Right now there are three tools available. And I think as a policymaker, you would want to rely on all three, and as a citizen in a country you'd want to evaluate all three to determine how your democratically elected representatives are doing. One is health status outcomes, and you know, there's always rankings of countries, but more importantly just looking at what's going on within a country, from state to state here or from province to province in Canada or even in smaller units. Second, there is the amenable mortality indicators, and that's Martin McKee's work, and I'm currently trying to do the same with one key amendable mortality indicator, diabetes, for Canada. But that tells you the responsiveness of the healthcare system, that 25 percent that Martin McKee was talking about, and that's one which, in a sense, is both a health status indicator, but also a healthcare indicator at the same time. But it tells you a lot about the healthcare system and the quality of the healthcare system. Those two are objective indicators. Then there's the subjective opinion polling indicator satisfaction surveys, community

surveys, and those sorts of things. That tells you whether people are satisfied or not, but it also gives you some idea of the level of expectations. And level of expectations can vary a lot from place to place. And it's not just patients; sometimes it's providers, physicians, for example, et cetera. I think you've got to look at all three, and if there are huge divergences between one indicator to the other, then you really do have to plumb down and find out why there are these huge gaps.

Yes?

QUESTION: Thank you. I have two quick questions. One is about the personal health records. My concern about that is that we will, in some sense, perpetuate consumer-driven healthcare in the sense of healthcare consumers, patients having to make decisions with very little information. So, I'm wondering if you perceive that as a—any sort of public health risk, the idea that, you know, a little bit of knowledge might be a dangerous thing, we then start to take these personal health records as evidence of a complete record, when in fact we have really no quality control over them. My second quick question has to do with a health status index. My concern there is that it is not—it may not be an objective measure and we may, in fact, negatively impact persons with disabilities for whom we've never really been able to figure out how they fit into that type of index.

ANSWER 1: I'll try to address the first question. Maybe you want to take the second question since you have more experience with the health measures. The personal health record conceptually has a lot of advantages and there's a very strong demand for the health record. And I think that it's going to happen and the early adaptors and the innovation that's going on right now indicates that people really want this and some providers actually really want it also, because it equalizes the relationship and helps change from a top-down sort of approach to decision-making to building a more informed patient. But just to go out and give people their health information, my goodness, the wraparounds that would be necessary to help people understand what—you know, what does chloride mean, that would just be a very daunting task. And what we would expect to happen - I think we're seeing evidence of that - is this creates a space for innovation where the entrepreneurs will come in and figure out how to create informative, creative, exciting ways to educate people about what does their health information mean, almost in the same way - I don't mean to champion a particular product - but Quicken for financial management where, you know, I don't know if many of you have used it, but the first time is, like, "Oh my gosh, this is so hard. I don't understand. How do I get this into my taxes? What is this form?" But you begin to see the system improves and people respond to your confusion and your needs and they develop creative ways of helping you solve your problems and it's a feet-forward mechanism. So, I don't see any reason why that wouldn't happen in health. I think the appropriate safeguards need to occur and people aren't going to be prescribing for themselves. And even without having your own personal health record, I think we are at risk for the boutique of information that's out there. So, there are all kinds of opportunities for people to be led astray with health information or junk science or pseudo information that's there. And you're speaking, you know, to the importance of medical literacy and I think this is just one more element of it. But the advantages of being able to have a complete health record, for many people, are a really important driver of allowing that information to come together and then thinking about how to make that knowledge, as opposed to data or danger.

ANSWER 2: Well, I can't speak to the index of well-being in terms of disabilities except that I would presume, of course, that there would be indicators in terms of certain classes of disabilities, and those would be pretty important in such an index, in the same way that many of our studies, in terms of marginalized and vulnerable populations assume that our aggregate results, in terms of health status are not going to tell us very much about those populations. And populations with disabilities, you need to study separately and you need to figure out exactly what the impediments are, in terms of access and what the problems are, in terms of quality. And in access, that leads to, then, policy in terms of funding reforms, and quality, it will lead to health services types of changes and reforms. And certainly I have seen a fair amount of that work, and I don't see that, if anything, that that work does the opposite. It actually is able to bring to light the kinds of challenges faced by disabled groups, in terms of access and quality. And it encourages, then, governments to target that in a way that I didn't see 15 or 20 years ago. So, I see these kinds of indexes as actually being helpful.

ANSWER 3: I would just like to second that only personal anecdote. I had the privilege of attending the national Special Olympics for people with intellectual disabilities, and as a prelude to that athletic contest, they do a health screening of the athletes. They have the worst health statistics of any group in America. They don't have dental care; they don't have vision care; they don't have foot care. Many of them, even at a young age, boys greater than girls, have osteoporosis. Girls never get pelvic exams. There're all kinds of complexities involved, and until you really put the numbers out, you know, it's an invisible problem because they fade away into the metric of the whole. So, I agree with you that it doesn't obviate the need to really be sensitive to special populations and to be sure that we're adequately framing and making visible where the disparities really exist. That was absolutely an eye-opening experience for me and it led to some important programmatic changes at CDC.

We've run a bit past our time, but this has been an exciting kickoff to the Health System Transformation Seminar Series. I want to thank our speaker, Dr. Gerberding, and our two discussants, Drs. Saltman and Marchildon for a really stimulating afternoon. Please join us now for a reception right outside. Thank you all very much.

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