

US Public Health Service

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For the first time in almost years, the responsibilities of the Surgeon General stand as separate entities. During the previous years, the Surgeon General and the Assistant Secretary for Health were joined in the same person and office. My major effort as Surgeon General since the first of the year has been to define the scope and responsibilities of this office. Before sharing this important task with you, let me touch in general on major health concerns of the Public Health Service.

An estimated \$247 billion was spent for health care in 1980, an amount equal to 9.4 per cent of the Gross National Product. Health spending was 15 per cent higher than in 1979, compared with an increase of 8.8 per cent in the Gross National Product. On a per capita basis, 1980 health spending from all sources amounted to \$1,067. Of that amount, \$450 (42 per cent) represented spending by federal, state and local governments.

Against this background, HHS Secretary Richard S. Schweiker convened a task force last spring to find the best ways of injecting greater efficiency into America's health care system. The administration believes that this approach can be the greatest single force for holding down costs while delivering quality health care.

Using the best thinking we can find, we have been pinpointing what we know and do not know about health competition. We are studying ideas that have already been tested, as well as new ones. For example, we want to know how we can give employers and employees incentives to choose cost-effective health insurance coverage that more closely fits their actual needs.

We know that people are increasingly purchasing more and more comprehensive first-dollar coverage, which insulates them from the true cost of the health decisions they make. We are all paying for this trend in higher insurance. We must also continue to encourage the development of health care delivery systems that provide quality care at a lower price. It is the investment and innovation from the private sector that will expand the number and types of available health plans and make choice a reality.

In the case of the Public Health Service hospitals, we believe the original need of two centuries ago has long been fulfilled. Long underutilized, these hospitals can now go to public and private ownership.

I have a particular interest in the area of prevention and the promotion of health. This commitment by the Administration runs through not only our research programming, but also the conduct of many of our remaining categorical programs and our approach to providing assistance to states, territories, and foreign governments for the pro-

grams they run. While prevention is uppermost in our thinking, it does not and will not replace other approaches to care that are appropriate, such as improved diagnostics or the introduction and strengthening of modalities of treatment.

However, it does appear that the federal government may be the most appropriate as well as the most capable mechanism for initiating this major re-orientation of thinking in the field of health and medical care—this new accent on prevention.

The costs of detection and treatment of lung cancer or cardiovascular disease are many times the cost of getting people to stop smoking. I would include in the costs not just the dollars paid out for certain services, but also the losses in income suffered by the individual and his or her family, plus the losses in productivity suffered by that individual's employer.

A group of 2,000 experts from outside government, representing a broad spectrum of public health, has developed 15 goals for the public health community in the field of prevention—goals to be met by the year 1990. We in the Public Health Service are completing implementation plans to address each of the areas and will present an outline as to just what the PHS contribution will be in achieving the goals.

The 15 goals are summarized in a published volume called *Objectives for the Nation: Promoting Health and Preventing Disease* (available from the Centers for Disease Control). The subjects include occupational health and safety; accident prevention and injury control; toxic agent control; lifestyle and personal or family behavior; the abuse of alcohol and drugs; cigarette smoking; the problems of stress and violent behavior; the mounting complexity of sexually transmitted diseases; and dental health problems.

The Office of the Surgeon General has a particular concern for the health problems of the aging in our society. Many of our elderly today are survivors—survivors of diseases that would once have killed them—stroke, heart disease, and others.

While the record has been excellent in prolonging life and allowing our senior citizens to lead better lives, we must do even better in the future as their numbers dramatically increase. We have 25 million senior citizens now; by 2010 there will be 50 million. We must absorb the fact that people are living full, active lives on into their 70s and 80s and, therefore, each person over 65 deserves as much of our health promotion effort as does each person under the age of 65.

We must also face the fact that the increasing age of Americans creates additional stress on our health care resources. The elderly are the heaviest users of hospital care,

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and their rate of hospitalization has increased while the rates for all other age groups have decreased.

The need for nursing home care also rises sharply with age. Over 20 per cent of the population over age 85 are living in nursing homes and the cost is high. Nursing home expenditures doubled between 1975 and 1980 and are projected to double again in 1985. This, too, is an area that needs study and careful planning.

Another area of interest where I feel the Commissioned Corps can plan a major role is in major health care emergencies. Our officers have a proud record of accomplishment in recent emergencies (e.g., Legionnaire's Disease and toxic shock syndrome), in moving in to help people threatened by the Mt. St. Helen's erupting or the incidents at Love Canal and Three Mile Island, or in screening the thousands of individuals and families who sought sanctuary here from Southeast Asia, Cuba, Haiti, and other countries.

Let me now describe in more detail the major components of my office in terms of objectives. I have four major components within the Office to meet my desire to provide effective, visible oversight of major initiatives.

The Office of International Health serves to assure effective US participation in the programs and activities of international health organizations. During most of my professional career, I have been involved in improving health care throughout the world. Through this office, it is possible to formulate overall US Government policy for international health, and foster and facilitate the participation of US Government agencies in international health activities. A major objective of this office is to ensure adequate and appropriate policy guidance for and coordination of the ongoing binational cooperative health programs.

Dr. Faye G. Abdellah serves as Deputy Surgeon General and Chief Nurse Officer. In relation to the latter, she provides leadership and coordinates nursing policy in the PHS and other DHHS components. She is the category officer for nursing responsible for 4,600 nurses, both Civil Service and Commissioned Corps.

Much of my surgical practice has been devoted to the **handicapped**. It is logical then that I would establish an **Office of Disability**. This is an area of deep personal commitment on my part. It is important that we build a national policy on disability using "health" as a springboard or model; **identify what services are offered in the private and public sectors; develop a roadmap of services; a means for communicating that roadmap and an attempt to involve those in and out of government for a broad based policy for the disabled in terms of services.** The year 1981 was the **International Year of Disabled Persons (IYDP)**. On behalf of the **White House, as Surgeon General, I serve as liaison to participating federal agencies which are building IYDP follow-up activities and to coordinate them into a national objective.**

Perhaps the most interesting and challenging office is "Special Initiatives." **These reflect major areas of interest and involvement of my staff. Here are placed the responsi-**

bilities for planning, developing, and implementing the following special short-term activities and monitoring other long range or ongoing activities:

AMSUS. For 1981-1982 I serve as your President. PHS is responsible for planning and implementing the 89th Annual Meeting, October 1982 in Orlando, Florida. This office serves as staff in coordinating AMSUS activities.

USUHS. This office will continue to have the coordinating and monitoring role for the PHS participation at USUHS which involved PHS students and faculty. We will continue liaison with training commands of the Army, Navy, and Air Force for placement of PHS graduates in residency training. This is an ongoing activity and one in which I take a close personal interest.

Emergency Preparedness. The Office of the Surgeon General has taken a leadership role in the coordination of the various PHS functions in the area of emergency preparedness in conjunction with FEMA, DoD and other governmental agencies. To this end, a medical officer has been detailed to OSC to provide liaison with PHS Office of Management and other PHS emergency planners, to rewrite *The Ship's Medicine Chest... Medical Aid At Sea*, and to develop a system for providing appropriate medical advice for ship-to-shore radio communications with the Coast Guard and Merchant Marine vessels.

PHEAP (PHS Employees Assistance Program). The Surgeon General has responsibility for coordinating and monitoring this program. PHS units are Washington area: Parklawn/Hyattsville, NIH, St. Elizabeths Hospital; Atlanta: CDC; plus various smaller installations of HSA, NIH and CDC. The office also assists in program evaluation with input from ADAMHA, HSA/DFEOH and provides consultation to the DHHS program.

Long-Term Care. The Surgeon General chairs a PHS task force charged with coordinating long-term care policies related to all programs within PHS and for the development of a long-term care policy, planning, and strategy document.

US Coast Guard. The Chief Medical Officer, US Coast Guard, reports to the Surgeon General for policy coordination and professional oversight of the quality and appropriateness of health care services provided by USPHS officers detailed to the Coast Guard.

In summary, I feel that the future of the Public Health Service and the Commissioned Corps is bright. We have weathered a variety of situations and have become stronger in the process. Our mission is public health. The professionals I serve as Surgeon General are experienced, dedicated, and uniquely qualified to carry out the mission to improve the Nation's public health.

At some future time, I hope to be able to describe some of our health relationships with the Federal Bureau of Prisons, the National Oceanic and Atmospheric Administration (NOAA), and emergency health care services aboard sailing vessels.