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Remarks

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This committee was bipartisan and in recent months had been discussing the future of healthcare which was why it was appropriate that I address them on this occasion.

Other witnesses had preceded me in previous sessions and I was followed by another group of witnesses and therefore chose to make brief opening remarks and spend the rest of my allotted time answering questions. The first issue I raised was that of the future relationship between technology and healthcare, pointing out that the American people have supported the assumption that they go together by way of taxes and donations willingly given. There is a counter trend however, and it is perhaps seen best in medicine where the profession itself questions the high cost and limited results of many of the new medical technologies. The place that this is seen best is calling on extraordinary measures to save or prolong the lives of the terminally ill. My opinion was that most people didn't want this, and certainly a substantial and vocal minority does want to be able to tell their physicians not to prolong their lives if there's any chance that that kind of life being prolonging will be qualitatively less than the life they've known.

There is a growing skepticism in other areas in reference to the relevance of technology to the major contemporary health problems. One of the keystones of public health is that each person makes key decisions day by day such as eating sensibly and exercising regularly, stopping the use of tobacco and other dangerous drugs, ensuring that the workplace is safe and healthful, and living at home or at play in a manner that will enhance not imperil one's health status. As people take hold of this opportunity to make decisions it's reasonable to assume that few will retain such complete and uncritical faith in high tech medicine as was the case say in the 1950s and 60s.

If this were to happen what would be the consequences? Well first the market for that technology would begin to shrink and the research community would respond accordingly with the academic pendulum swinging back toward basic research and away from product development. The call today is for new and less costly "low tech" responses that don't pretend to cure illness or repair disability but make it possible for say a disabled person or one with one or more chronic conditions to live an independent non-

institutionalized life. Other low-tech applications are needed in health administration for monitoring patient outcomes and measuring satisfaction and maintaining accountability.

As the dominance of high technology seems to be receding at the level of hands-on patient care we need to understand why that may be happening and what it could mean. Another issue is the change in relationship between public health and the health care system. Factors that work here are increased mobility of the American people, the rise in prepaid practices of one kind or another, and the shift in demography of our country called the “graying of America.” There already is a well established specialty in geriatrics and this specialty joins pediatrics and family medicine to divide up primary care and change our traditional ideas about continuity of care. That may mean many of the assumptions on which our health planning is based may still reflect the patient to system relationship that for many individuals and many institutions no longer exists. I used as an illustrative anecdote my experience with the Surgeon General’s Workshop on Self Help, which I went into in some length. I called attention to the fact that many of the concerns of “self-help” groups were the most serious public health problems we face today. Traditional fee-for-service medicine or tax supported public health programs generally do not respond to this intensely personal aspect of perceived health problems. I made a plea for closer cooperation between orthodox medicine and “self-help” in order to get the best out of available healthcare expertise.

I finally turned my attention to health, community values and public support. I presented them as a kind of corollary of the issues I had already discussed. Americans are generous to a fault, but they become impatient, for example, when the lifestyle of people is detrimental to their own health, the health of others and costs the taxpayer money. The result is that, in smoking for example, the non-smoking public is asking for new and stronger local laws. To curb cigarette smoking, health and life insurance companies have responded by charging higher premiums for smokers. This is, in a sense, public retribution directed against smokers. But it is also being exercised against drunk drivers, drug addicts, promiscuous and pregnant teenagers, and others who are perceived as deviating from the community’s standard of normative behavior. This led into my of repeated concern about AIDS and the concern of the public that some who contract that lingering and fatal disease did so through activity that the community regards as unsavory. I think that my point is made as the AIDS-related research and patient care will exceed 5 billion dollars this year. The challenge then would be to recognize – if and when it comes -- the reaction of the general public against high-risk individuals and try to channel it into more tolerant responses. It is important because what is at stake is the very basis of the American approach to health itself. As healthcare costs will take a larger and larger share of the gross national product, more and more American will look with greater critical interest not only at our system of health care but also at those directly benefiting from that system. That is participatory democracy in action. It could be painful for many of our citizens and we ought to be prepared for that. I then took questions from the audience.