Discussion: Session V

Margaret Mahoney (The Commonwealth Fund, New York, N.Y.): I will take the privilege of the podium to ask you, Mr. Jennings, how accurate information can flow more effectively to those who need it in the media. A lot of confusing information gets broadcast by the media precisely because they don’t have more complete and accurate information.

Peter Jennings (ABC News, New York, N.Y.): You have the benefit of having the medical press in attendance here and, as the debate continues, those of us in the general press will read the medical press more avidly than we have in the past. Most large television institutions now have at least one or two medical specialists on their staff. I would always make it a point of inviting generalist journalists like myself to conferences such as this one because while you have confused me with some of what you said today, I got several story ideas as well.

Mahoney: And that’s only fair. Dr. Lederberg, your point about the neglect of the menace to public health seems to be an issue that we ought to spin out a little bit more because it has profound cost implications.

Joshua Lederberg (The Rockefeller University, New York, N.Y.): The issue is rather elusive. It is difficult to talk about the level of future investment in public health on the basis of very limited anecdotal data. The fact is, however, that although the intensity of the debate has been very high regarding how important health care is and how it must be made available to everyone on an equitable basis, public health has simply not been part of that picture. Viewing these matters systematically one would say that, of course, a very careful provision for public health measures must accompany the private care aspects. It is not that anything adverse has been said about public health, rather it’s neglect of the issue, especially as reflected in very specific budgetary failures.

Bob Michels raised a very important point—that there are many other aspects of social activity that bear on health. But there’s little doubt that if health outcomes are your concern, the greatest leverage comes from interventions that are focused on public health issues. To some degree, public and private health can compensate for the consequences of the overcrowding, malnutrition, or personal neglect that are the results of much broader social causes.

But we have to avoid the trap of saying that these are such huge problems, that, even if they’re not intractable, they would consume all of our resources and therefore we can’t afford to concern ourselves with them. We must concern ourselves about very feasible and economical measures. We’re talking about 1% of the overall health budget—that would have an enormous effect on further outcome. You might ask what world health has to do with our own health, and I will answer that it has everything to do with it. This country’s recent repeated refusal to continue even its limited past levels of cooperation on global programs such as those on tuberculosis and malaria is shocking. It will come home to haunt us and it reflects a callousness about the welfare of people beyond our borders. The two cannot be separated.

Mahoney: Public health is not well understood as an issue or as a field. You will notice, that in most state departments of health the word public is left out of the title, which adds to the confusion about the department’s role in trying to stem the tide of some public problems, such as the low rates of immunization. Legislators and those responsible for the money do not see this as an issue of prime importance affecting the general well-being of the population.
UNIDENTIFIED SPEAKER: When I was a child I would see quarantine notices on houses where there was scarlet fever or whooping cough. We may have defeated those diseases, but other infectious diseases have taken their place. What are the rights of the patient in this regard compared to the rights of the public?

LEDERBERG: This question might be better directed to Dr. Hamburg, who has a very personal responsibility for addressing those concerns. We have a much more finally tuned sense of individual privilege, including the privilege to infect others, than we did 50 and 75 years ago, but in most cases the consequences are more nearly mitigated. There was a time when scarlet fever was a source of deadly contagion, while today it can almost always be controlled by antibiotic treatment and so we have set somewhat less stringent standards for quarantine. When it comes to multiple drug-resistant tuberculosis, we have the kind of hard case where there really is a major public threat and where some degree of imposition on personal freedom is totally warranted. These are always questions of balance between competing goods.

This question, of course, comes up most cogently and most poignantly with respect to AIDS. There the conclusion was drawn that individuals can protect themselves against infection, and that this was not a matter of a disease that would be transmitted by aerosol or by casual contact. Consequently there was no scientific basis for quarantine, particularly at a time when the disease had reached such a prevalence that there was absolutely no hope of containing it within the country. We have to deal with these circumstances one by one in terms of the balance between private and public good. The only infection today that falls within the framework of being such a severe threat, yet for which we can do useful things therapeutically for people who might have to be quarantined in one way or another, is multiple drug-resistant tuberculosis. Perhaps others will emerge.

MARGARET HAMBURG (Department of Health of the City of New York): I have little to add to Dr. Lederberg’s response, but he did raise the issue of tuberculosis, which has been a major major concern here in New York City and obviously a major focus of my activity. This issue symbolizes the potential conflict of civil liberties of an individual versus the responsibility of public health officials. There is no doubt that public health officials have an obligation to protect the health of the population at large, and this sometimes comes up against the issue of individual liberties. Tuberculosis in New York City has resurfaced and is at epidemic levels. The problem here is more intensely concentrated than in any other city in the nation, but it’s a national and international problem as well.

In the last few years we had to take a renewed look at the problem, and it was interesting to note that the laws concerning tuberculosis and quarantine were extremely outdated; they had not been reviewed in decades. So last year, in response to the magnitude of the epidemic and the threat of its spread, we revised the tuberculosis detention laws and we did two important things. One was to make the laws more strict, allowing us to detain people, not only when they’re actively infectious, but also if they had demonstrated repeated noncompliance with their therapy, because tuberculosis requires ongoing treatment over a period of many months, and indeed sometimes for many years in complicated drug-resistant cases. So although a person can become noninfectious fairly rapidly into treatment, if he or she does not continue the course of treatment, the disease can become reactivated. The patient again becomes infectious and often develops a drug-resistant form of the initial infection. So we made the law more stringent in terms of the detention capacities, but we also introduced greater due process than before.
Up until the time that we modified the rules, the Commissioner could simply order the detention of an individual with no recourse and no appeal mechanism. We introduced the right to counsel and the right to a hearing before a judge, followed by periodic review in a court. By doing these things we have set a new standard that applies to tuberculosis, but also may have relevance for other infectious diseases that pose a threat of communicability and thus a threat to all of the population. The core of public health is about protecting the health of populations. Sometimes this may entail making difficult decisions, but that’s the responsibility of being in public health.

ROBERT MICHELs (Cornell University Medical Center, New York, N.Y.): I agree with Dr. Lederberg and Dr. Hamburg, but would add a footnote that illustrates the sometimes blurred boundaries between public health and other social policies. The general issue we’re discussing is a very old one going back at least two millenia of the boundary between individual liberty and the public good, when that individual liberty becomes public peril. Traditionally that is our accepted limit. Excepting the tuberculosis model, one can argue for an equally or even more serious public health peril in the availability of handguns in our society. Nevertheless we have elected at this point to state, astonishingly to some of us, that a citizen’s liberty to carry a concealed weapon is so vital a social value that we can tolerate its being a major source of death of young men in our society. In health terms this issue is probably larger nationally than the problem of tuberculosis. This isn’t part of what we usually construe as a traditional public health problem, but the health outcome related to it, which also revolves around the same issues of the public interest versus personal privilege, is even more important.

ALAN DEMAYO (New York Hospital–Cornell Medical Center, New York, N.Y.): Mr. Jennings, don’t we have the right to discuss the negative aspects of some of the health care proposals without being accused of fear-mongering? I haven’t read the health bill in its entirety—it’s 1,200 pages long—but some who have read it and interpreted some of its provisions have reached rather frightening conclusions. For example, the law may prevent a patient from going outside the system to buy a better basic health coverage even after paying the mandatory premium to an HIPC or health insurance purchasing cooperative. The bill—Clinton’s original plan—guarantees you a package of medical services, but they are unavailable unless they’re deemed necessary and appropriate, a decision that will be made by a government board rather than by a patient and his doctor. Escaping the system by paying out of pocket to see a specialist for tests and treatments a person thinks he needs will be almost impossible.

To be seen by a doctor, a patient must show proof of enrollment in one of the health plans offered by the government. The doctor can be paid only by the plan. The bill requires that this visit must be reported to a national data bank containing the medical histories of all Americans. If that isn’t the brave new world of 1984, maybe it’s going to be so in 1998! I think that we have a right to look into the bill’s proposals.

The government investigated health maintenance organizations and care of geriatric patients and found some quite wanting in the allocation of resources. The federal government has been quite lackadaisical in following up complaints against these practices; for example, a Florida Humana HMO, offered to Medicare

---

*a* McCaughhey, Elizabeth. Health plan’s devilish details. The Wall Street Journal, September 30, 1993.

*b* Consumer Reports, August 1992, p. 529.
DISCUSSION: SESSION V 191

beneficiaries, was cited two years ago. Again, I feel we have the right to ask about the provisions without being accused of fear-mongering.

MAHONEY: You are asking for forums in which these kinds of discussions can proceed. What you read was in fact what is in the Clinton Act, but the way it was presented to you is from a negative standpoint. It will be everything that you say, but the issue really boils down to how things are carried out and under whose auspices. The debate is going to broaden. The lack of information is the most important issue right now. Some ads are now appearing under the auspices of the League of Women Voters and the Henry J. Kaiser Family Foundation on radio and television and in print. These ads are trying to give some highly specific guidelines to the public for evaluating health care reform.

HOWARD FILLIT (Mt. Sinai Medical Center, New York, N.Y.): I want to comment about the future of geriatric practice and managed care. Managed Medicare risk contracts have been growing rapidly and are coming our way. There's an "age wave" coming. The first baby boomers will be turning 50 in 1996. This demographic peak has been described by Ken Dychtwald as an elephant walking down a road step by step by step. We didn't see it coming when we were building elementary schools in the early 50s and we didn't build enough high schools in time either. Now baby boomers are aging, and we are suddenly going to have 76 million people over the age of 50. The aging of our society is a problem throughout the industrialized world and will have an enormous impact not just on our health care systems but on our entire economy.

In addition to the social problem presented by the elderly, these patients have complex health problems that represent a difficult challenge to the physician working in a traditional office, without a social worker or nurse practitioner. The current situation discourages home visits and innovative ways of keeping the elderly out of hospital. The fragmented system that we currently have under Medicare is not optimal. Systems like Onlok in San Francisco, which have been around for a long time, are extremely successful: they get a very high patient satisfaction rate and they save money. I'm not aware of the data you're referring to, Dr. DeMayo, but I disagree with what you've said, and I think that managed care does have a lot to offer. Perhaps as a geriatrician I've been down so long everything looks like up to me, but I'm very hopeful that the coming changes in our system are going to help us to provide comprehensive, multidisciplinary care to elderly patients. I believe that managed care will give me the ability to provide care in innovative ways that are not possible in the current medical model.

MAHONEY: Dr. Fillit, I think the problem is one of seeing managed care as a panacea. Not enough is known about managed care to declare it as the only answer. A number of "quick and dirty" studies are under way right now to try to find out more about patient satisfaction and cost, but that information does not exist at present.

FILLIT: The other thing I might enter into the debate is something that Dr. Lerner mentioned this morning, which is that regardless of what the government decides, managed care is coming our way. We on the East coast are living in a wonderland—in California and other areas there are markets that are already 90% penetrated with managed care, and this wave is inevitably going to come here. What the government does in Washington regarding health care reform is highly unlikely to change the expansion of managed care throughout our society.

MAHONEY: You're right.

JENNINGS: I'd just like to make a comment since a question was asked of me as to whether or not we have the right to debate this. The point is that it's already
being debated quite vigorously on the pages of the *Wall Street Journal* among other places. So I just want you to know that without a shadow of a doubt the rest of us are going to be party to the debate as well.

I have another comment apropos of Dr. Hamburg's and Dr. Michel's remarks about public health and violence. It is interesting to see that the Centers for Disease Control and Prevention recently put the question of violence as a public health issue on its agenda.

KEN TERRY (Montvale, N.J.): I have a question for Dr. Reisman about managed care. You indicated that primary care doctors might not have a knowledge of the latest medical techniques or know when a patient should be receiving specialized care. Considering the gatekeeper role of primary care doctors in HMOs, do you feel that this lack of preparation on their part will inevitably lead to a deterioration in the quality of care?

LONNY REISMAN (William Mercer, Inc., New York, N.Y.): Yes I do, and that was primarily the point I was trying to make. If we look at the implications of denied access to appropriate specialization—I don't necessarily mean technology, because I'm talking about the cognitive skills of specialists as well—and if we measure the economic and the personal costs for patients that result from delays and denied access, we would be astounded at the impact it has on the health care economy. In some HMOs there is a notion that primary care physicians can operate to a large extent in a vacuum. My concern is that these physicians are going to be penalized for trying to access the cognitive as well as the technical abilities of specialists. This will raise costs by delaying intervention. Probably the best models that I've encountered for accessing and adequately exploiting the skills of specialists are the group models, most of which are on the West coast. Imagine a scenario where you've got an entire group of physicians working together at risk, budgeting or managing a certain amount of money and making sure that patients receive the necessary care at the earliest possible stage. I can't emphasize enough what I consider to be the very severe consequences of late identification and suboptimal management of the diseases that are driving so much of the health care dollar and are associated with so much pain and morbidity on the part of patients.

JONATHAN TOBIN (The Clinical Directors Network, New York, N.Y.). We work with the medical, dental, and nursing directors who practice in community, migrant, homeless, and HIV health centers. If we look at the question of work force supply no scenario exists that would have enough specialists to provide the kind of care that you believe is necessary or desirable, Dr. Reisman. Likewise, current analyses also suggest that the workforce supply of primary care providers is inadequate. We're at a point now where we have to make a decision about what model of care to further develop, and the way I'm hearing your presentation is that it's an either/or situation—it's either going to be specialty-driven or generalist-driven. If it's generalist-driven, it's not going to address sufficiently the health care needs given the proven technologies that we have. Yet, the cases that you have identified are cases that are very amenable to prevention and early detection, which are very suitable in the primary care environment. You picked cases that would strengthen the argument that if access to primary care were made completely accessible, it might make the requirement for the type of specialty care that you're suggesting unnecessary.

REISMAN: First, I didn't make myself clear. I wasn't suggesting an either/or scenario—I was suggesting a joint cooperation between primary care doctors and specialists. What I'm concerned about is the penalties associated with what some managed-care organizations consider to be excessive referrals or access to special-
ists. So we need to take another look at the current structure and identify mechanisms for accessing both the technical and the cognitive skills of specialists. I mentioned some of the common conditions that would be amenable to primary care precisely because we all expect and assume that those cases are treatable by primary care physicians, but in reviewing the literature as well as thousands of cases from HMOs and other managed-care organizations, I can tell you that the late manifestations of a disease that could have been managed more appropriately earlier are a major draw on the dollars that we’re spending on health care, not to mention the pain and suffering for patients. If patients don’t receive tight glycemic control in diabetes, ultimately end-stage renal disease, peripheral vascular disease, and heart disease will result. You know that, so I don’t think you’re arguing about the benefits of that sort of sophisticated primary clinical care. I’m just suggesting that this level of sophisticated primary care is not out there right now. It is not keeping up with the explosion in technology and new information about management, treatment, and identification of disease. When I started training I saw the first AIDS cases in 1981; we didn’t know about drug-resistant TB, and we didn’t have all sorts of gadgets for revascularization. I don’t think it’s feasible to keep up with the pace of innovation while you’re managing that many patients nor can you be expected to provide real state-of-the-art, optimal management of these patients. So I’m just suggesting greater access to the expertise that is already there and turning more over to the physicians with the most experience in managing these conditions before they become so complex that they inevitably become long-term issues.

**FILLIT:** As a primary care provider, I take offense and disagree with these comments. I think common things occur commonly. To say that a primary care provider can’t take care of common conditions that affect 95% of the population 95% of the time implies that primary care providers are not good doctors, and I don’t think that’s generally true. There are a lot of good primary care providers out there who are very competent and capable of providing care for the 95% of conditions that occur commonly. The inadequacies in diagnoses can go both ways. As a primary care provider, a lot of patients are referred to me after they’ve seen one specialist after another and not one has seen the big picture. Another remark I took offense at was that patients ask for a good cardiologist or gastroenterologist or whatever, but never ask for the name of good primary care provider.

Again, my entire practice is filled with people looking for a primary care doctor. They have a cardiologist, they have a neurologist, they have a urologist, but nobody is “their doctor.” I think that the public recognizes this problem and is looking for an answer. They understand primary care. They’d like it to be the way it was back in the old days when they had a doctor. I agree that a balance is needed between specialists to take care of special problems and a personal doctor. But I think the complaint that’s driving the debate is very much the public awareness that a lot of people don’t have primary care doctors.

**REISMAN:** The question I would ask is: for the 5 or the 10% of cases that are not readily or optimally managed by primary care doctors, what percentage of our health care costs are related to the mismanagement of those situations? I’m simply proposing that we need to develop a mechanism that is going to focus on that small fraction of cases that drives so much of the problem we’ve got.

**FILLIT:** I do not believe that a significant percentage of our health care costs are due to mismanagement of diseases by primary care doctors. I do believe that a much higher percentage of costs is related to unnecessary care provided by specialists.
MICHELS: This issue is very important and interesting, both inherently and for the light it sheds on the quality of the debate. The question is: who do we want for the "person-power" to provide personal health care? The panel is talking only about physicians. You've not heard a word about public health nurses, about osteopathic physicians, who are a critical and heavily primary care-dominated group of caretakers, or about others in the health care field. Secondly, the question of the optimal mix of health care providers for a population clearly requires a whole set of secondary discussions about that population. It seems to me very unlikely that the answer to that question for Idaho is the same as that for Brooklyn. Yet the national debate has not paid significant attention to those cultural and regional and other differences in populations. It seems to me very unlikely that the right answer to that question for people over 70 is the same as that for people between 25 and 35.

One of the differences at both ends of the life spectrum is that if you're sick, you're likely to have multiple interacting problems, whereas when you get sick at age 30 you have one thing wrong with you, that month at least, and when you get better you're well. When you get sick at age 70, the real problem is whether the prescription written by your doctor interacts with the 14 other medications you're already taking and whether there is someone who understands that pattern. So the answer is different in different communities and in different age segments. The real concern is the context of the dialogue. One thing the mix does is change costs. Another thing the mix does is affect the quality of care. There's a widespread concern, indeed fear, that although the public dialogue is about quality of care, that dialogue is being driven by cost concerns. Both the public and the medical profession are concerned that formulas will be imposed or definitions—like whether an obstetrician is or is not a primary care physician—will change from month to month. All of these are elements in the political process of controlling health care costs, but they are not elements of a dialogue on how to improve the fit between the nation's personal health care needs and the manpower available to provide it.

The cheapest way to control costs is to provide no care. It is widely believed that a higher ratio of primary-to-specialist care will control costs. At the same time it doesn't take much philosophic sophistication to divine the public's desires. You know what the public wants when you look at the relative reward the public accords to specialists versus that given to primary care doctors. The public's interest is reflected by the ratio of incomes of those groups.

JENNINGS: Dr. Fillit said emphatically that that wasn't true; could I beg an explanation?

FILLIT: It is an historical anomaly that subspecialists are making fortunes. This situation was totally created by the introduction of Medicare in 1965. When surgeons began practice around the turn of the century, they had new procedures to offer which the public valued. But the discrepancy in income between surgeons and physicians, who provided cognitive services, was never extraordinarily great. Public recognition of the value of surgeons did not create large income differences. Suddenly Medicare was introduced and it created a fee schedule that is totally artificial. It has no basis in reality. Why should someone who has the same degree as I do, with the same number of years of training and who works just about the same number of hours, get ten times the Medicare reimbursement that I would get for providing health care? It doesn't make any sense to me because I also help people and save lives.

MICHELS: As a purely cognitive specialist I couldn't agree more, but the public, when it is paying its own bills, believes that cataract surgery, brain surgery,
or heart surgery is worth more per hour than treatment provided by the most sophisticated cognitively oriented specialist. The public is wrong, but I have no question about what its values are.

**MAHONEY:** I don't think you can safely say that the public feels that way. We have never done surveys that would yield that statistic; it wouldn't be possible right now.

**REISMAN:** One solution might be consideration of capitating specialists. That would limit their fees, and limit their access and incomes, but would still provide the sort of access that is necessary to optimize care. That model has been adopted on the West coast. Specialists make as much money as the primary care physicians, which I think is appropriate, and they do procedures that are necessary only when they're necessary, but the cognitive abilities are made available to the primary care physicians in managing patients.

**JENNINGS:** I listen to this with the greatest fascination because I think you're playing right into the perceptions that the public already has. I think you're right, Dr. Fillit, in the first case, and I think you're absolutely correct, Dr. Michels, in the second, that when we're in trouble we're more inclined to pay for specialists, and I think we're even more inclined to pay for them when our insurance is taking care of it. But I also take your point on how needs change region by region. In the state of Minnesota the need for primary care physicians was so great that the entire state system was redesigned in order to make it easier and more economically viable for young medical students to become primary care physicians. It seems to me that the ultimate layout of health care reform must provide the best benefits—medical and economic—for the nation as a whole.

**SAMUEL SILVERSTEIN** (Columbia University, New York, N.Y.): We do a good job of "med speak" here, and the cacophony of agreement and disagreement in this room is not always intelligible to the general public. Even Mr. Jennings, when he came in, said he wanted to be last so that he could orient himself and figure out exactly what we were saying. The quality of the public debate and the extent to which the public is being exposed to that debate is critically controlled by the organizations for which we work. The foundation world as well as the TV world needs to help elevate that debate and make it more accessible to the public. There are opportunities for public health announcements on prime time TV, such as the kind we saw recently with regard to condoms and the transmission of AIDS, but we've seen practically none of that. Mr. Jennings, could you please tell us how we can communicate our message more effectively and let us know whether there are ways in which the TV networks can be used more effectively to make this debate more complete, more continuous, and have a content which is other than sensationalized.

**JENNINGS:** This is an eternal question for journalism as you know. I myself take some issue with my own company as to whether or not we should have condom advertising in prime time. If I were the boss, we would have, but since I'm not you can see where the ads have been positioned. You address something more serious, which is the public or social responsibility that journalism should have for dealing with the debate in the profound way it is being treated in this forum. I don't know the answer to your question except to say that those of us who work for allegedly serious news organizations have tried over time to deal with it in a nonsensational way, and that my craft or profession is not unlike yours. There are those who go for the quick fix and there are those who go for long-term therapy.

I have maintained a belief in the ability of the American public to arrive, over an extended period of time, at what is essentially a reasoned truth. We're seeing
Some of that in terms of our engagement at the moment in the debate over America's role in Bosnia. It's taken time to bring various components of society to the table. It is also going to be true in time about health care, which speaks not only to how we are as individuals, but also to how we wish to engage with our neighbors. At this point I think those of us addressing these issues seriously still outnumber those who are not and I think we'll manage to stay ahead of them.

Silverstein: I would like to ask Margaret Mahoney whether the foundation world can finance an information campaign like that of the League of Women Voters.

Mahoney: A foundation is funding such an endeavor—The Henry J. Kaiser Family Foundation is paying for a series of ads about the health care proposals. Foundations cannot lobby, but they can provide educational programs. An educational program on mental health will be run by the Basilon Center for Mental Health Law in Washington with help from a John D. and Catherine T. MacArthur grant. The Commonwealth Fund has a number of short, quick-term studies under way that we will be putting into the marketplace. I should like to suggest that in order to stimulate informal debate the New York Academy of Sciences and the New York Academy of Medicine should provide ongoing opportunities for clarification of the issues.

Sally Hipp (New York State Department of Health, Albany, N.Y.): I work in the field of public health. A lot of the impetus for this meeting and for the debate that's going on in health care comes from the fact that there are 25 million uninsured people in this country. Many of these uninsured people are the same people we see in public health, and their needs are often a great deal different from needs that have been talked about at this meeting. Take migrant workers, for example. The questions of what will happen in research or to pharmaceutical companies are too far removed from their most basic needs. It is less a matter of whether their health care will be delivered by an HMO than it is of getting someone to take them to a doctor—they literally have no transportation. We had a syphilis outbreak in this state, but found that the medical profession was not ready for it because most physicians had never even seen a case of congenital syphilis. So in medical school we need a bit of training in epidemiology and public health issues. We need to focus on what the 25-million uninsured people don't have more than what we are going to lose. In other words, it's not a case of lowering the ceiling, but, rather, one of raising the floor. To sum this up, I would suggest that the Academy hold another meeting dealing with the people who lack insurance and how that affects public health issues and how these topics can be insinuated into the ongoing debate without detracting from the issues of excellence that clearly exist at other levels of medical provision.

Mahoney: Thank you for a very constructive and fundamentally important idea.