

Nova Law Review

Volume 26, Issue 2

2002

Article 6

A Conversation with Dr. Louis Sullivan

Louis Sullivan*

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I. INTRODUCTION

What I thought I would talk about today for this midday session is the challenge, as well the promise, of addressing health disparities in the United States. By health disparities, I mean a number of things. First of all, we have as we look at various segments of our population, differences in life

* Kathy Cerminara: Welcome to the Nova Southeastern University School of Law and I am pleased and proud this year to be the Goodwin Professor. Which means that I have hosted and had the pleasure of bringing into our school a series of very special speakers. Today we have the final speaker in that series, a very special speaker, the very honorable Louis Sullivan M.D. Louis Sullivan started as Secretary of Health and Human Services ("HHS") from March 10, 1989 through the end of the senior President George Bush's administration and since 1993, January of 1993, he has been President of Morehouse School of Medicine in Atlanta. As head of the Department of HHS Dr. Sullivan administered the federal agency responsible for major health welfare, food and drug safety medical research, and income security programs for the American people. Dr. Sullivan went to HHS from Moorehouse at which he played a founding role. And he joins us today as a member of various medical organizations, the founding President of the Association of Minority Health Profession Schools, and having served a variety of other positions I am so very pleased to welcome him and please join me in welcoming him.

expectancy, differences in incidence of diseases, differences in access to healthcare, and differences in health insurance coverage. So, a variety of factors infringe upon the health status of our citizens. Certainly, in a democratic society, the goal is to provide equal access to services provided for all of our citizens.

II. HEALTH CARE ACCESS DISPARITIES

First of all, I think the United States of America has the most advanced and sophisticated healthcare system in the world. How do I support such a statement? As you know the Nobel prizes in physiology and medicine worldwide are considered premiere scientific recognition awards. Although the United States has only 6% of the world's population, half of the Nobel prizes in physiology or medicine of the twentieth century were received by scientists in American laboratories. That is a measure of the quality of our scientific enterprise. Secondly, when a new pharmaceutical reaches annual international sales of one billion dollars or more, because of great acceptance and utility, it is then called a "blockbuster" pharmaceutical. Of the blockbuster pharmaceuticals of the twentieth century, more than 40% of them came from United States pharmaceutical companies: a measure of the effectiveness and efficiency of our pharmaceutical industry. Thirdly, as a nation we have the most highly trained health personnel, not only physicians and dentists, but also nurses, allied health personnel, and others.

It was not always that way. In fact, many of you have heard of the Flexner report, which was issued in 1910.¹ This report was issued by Dr. Abraham Flexner, a microbiologist at Rockefeller Institute in New York at that time. This report was commissioned by the Carnegie Foundation, with their long interest in higher education. Over a two-year period of time Professor Flexner visited all 148 medical schools in the United States and Canada to assess their effectiveness. At that time Europe, not the United States, was the leading center for medical education, with such Universities as Bologna, Heidelberg, Edinburgh, London, and others considered to be the pinnacle of training in medicine. The Flexner report was a revolutionary and cataclysmic report. It is still available in medical libraries, and I would

1. Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching*, (Bulletin No. 4 1910), available at http://www.carnegiefoundation.org/eLibrary/docs/Flexner_report.pdf (last visited Jan. 27, 2002).

invite you to read it because it has a brief description of every one of those medical schools.

Dr. Flexner recommended strengthening medical education. He recommended that some schools should be closed, and he was very critical of the quality of curriculum, or the absence of curriculum. Many institutions were proprietary institutions, where the owners were usually physicians who had simply obtained a license or charter from the state to operate a medical school. There were no accrediting bodies at the time. Because of Flexner's report, and his recommendation of the model that should be adopted, similar to Johns Hopkins Medical School, a number of changes occurred. By 1925, the number of medical schools had been reduced from 148 to 80 and remained at eighty over the next thirty years. Then in the mid-1950s, with federal, state, and private support, the United States began an expansion of medical education, including the development of forty-five new medical schools. The number of medical schools in the country grew to 125. With the number of improvements that have occurred, there is no doubt that we now have the most highly trained health care personnel in the world. We have people coming from around the world to the United States for care because it is often not available in their own countries.

Fourth, our technology is the most advanced, with medical devices, clinical treatment protocols, and diagnostic procedures that are readily available around the country. Fifth, as a nation we invest more dollars in biomedical research than any other nation. For the current year, that investment comes to seventeen and a half billion taxpayer dollars invested by the National Institutes of Health ("NIH"), not only in research carried on the NIH campus in Bethesda, Maryland, but research that is supported in medical schools and hospitals, and other health profession institutions around the country. That seventeen and a half billion is matched by twenty-six billion dollars invested in clinical and applied research by industry, that is, by medical devices industry and the pharmaceutical industry. The result is, virtually every week we read about some new system of biology which has been deciphered, such as, the genetic code; the discovery and use of stem cells; the ability to grow nerve cells in the laboratory; and many other advances that formerly were not thought possible.

Well, in spite of these advantages, our system also has some problems. Our healthcare system is the most expensive in the world. We spend more than \$4000 dollars per capita in our healthcare system for every man, woman, and child in the country, virtually double that of most Western nations. In spite of our expenditures, some nations do better than we do in a number of health indicators, such as infant mortality. We rank around

twenty-two in infant mortality, and other indicators of health status. So we have a distribution problem in our country so far as health services and access to healthcare.

We have a paradox: not everyone has access to health services, because of economics and geography. We have forty-three million Americans without health insurance, and an equal number who are underinsured. Second, there is a geographic maldistribution of health professionals and health services. In many fields we have adequate or even excess number of physicians in such areas as ophthalmology or dermatology, but inadequate numbers in primary care fields such as family medicine, general pediatrics, and general internal medicine. There are also cultural barriers to healthcare, which is increasingly important with the expanding diversity of our country's population. There are also differences in education, which have an impact upon health status and access to health services.

III. MINORITY HEALTH DISPARITIES

Finally, there remain vestiges of discrimination, or often, even unconscious bias in the allocation of health services and resources. This bias has been shown, for example, in two studies. One study involved the Medicare population, showing that African-Americans in the Medicare system who have chest pain are less likely to have a comprehensive cardiovascular evaluation as are whites. A similar study, in the Veterans Administration Hospital system, showed that there were similar glaring gaps in the quality of health services that black veterans received. So we are faced with glaring gaps for decades in the health status between the white population on one hand, and the nation's minorities on the other. Now, poverty does play a major role in this, but poverty is not the total answer.

The result of all of this is that in this year 2001, black Americans have a life expectancy that is significantly shorter than that of white Americans. For white females born this year, life expectancy approaches eighty years. That compares to the life expectancy of black females of seventy-four years, a six-year difference. When we look at our male population we see that for white males, the life expectancy for a white male born this year is seventy-four years, whereas for black males it is sixty-six years. An eight-year difference in life expectancy. I was visiting a facility in the District of Columbia just a week ago when I learned that the life expectancy for black males in our nation's capital was only sixty-four years. The most striking gap is between white females of eighty years and black males of sixty-six years. An astonishing difference of fourteen years in life expectancy in this

most affluent technologically advanced country in the world. What this also means is that for black males, on average, they only draw about two years of social security retirement benefits, whereas for white females they draw an average of fifteen years in benefits from a system in which we all pay, according to our income during our working years.

IV. CAUSES AND CURES

A. *Causes*

What are some of the reasons for the disparities in health status affecting the American minority populations versus the white populations? As I mentioned, higher death rates in minority segments of our population are a result of many conditions. The long list of conditions include: infant mortality rates that are twice as high in the African-American population as the white population; and one and a half times as high in the Latino population as in the non-Latino white population; higher death rates from diabetes, heart disease, stroke, kidney failure, AIDS, prostate cancer, violence and other causes. Now, if you look carefully at all of these conditions there are certainly biological determinants that are very important. I maintain as well, that individual health behavior contributes significantly to health outcomes over a sustained period of time.

We also note, that the United States since its founding has always had a shortage of minority physicians. I remind you that during slavery in many Southern States it was illegal to teach slaves to read or write. Thus in 1864 with the Emancipation Proclamation, a number of illiterate adults were released to fend for themselves in our country. Although that was more than 135 years ago, some of the lingering consequences are still affecting our population. In 1950, 2.1% of all United States physicians were African-American, even though, African-Americans comprised 10% of the United States population at that time. In the mid-1950s, because of the projection by a number of groups of a pending shortage of doctors, our country began a unique and remarkable expansion of medical education.

This continued until 1981, resulting in the 125 medical schools we have now versus the fifty that existed in 1950. Some of those new schools include the University of South Florida in Tampa, affiliated with Nova Southeastern University today, and other schools around the country, of which my school, Morehouse School of Medicine, is one of those forty-five newer medical schools. We are now graduating nationally some 6000 physicians every year

as opposed to 8000 physicians we were producing up through the mid-1950s in our country.

In spite of efforts over the past thirty or more years we have only increased the percentage of physicians who are African-American from 2.1% in 1950 to only 4% today, even though the African-American population is now 13% of the nation's population. Less than 8% of today's medical students are African-American, and less than 7% are Hispanic-American, even though Hispanics comprise 12% of the United States population. So, one of the lingering issues we have today is the continued shortage of health professionals from our nation's minority population.

In 1995, Dr. Miriam Komoromy and her colleagues reported in the *New England Journal of Medicine* that those communities with a high percentage of African-Americans or Hispanic-Americans among their citizens had a lower number of physicians than did comparable white communities with similar socioeconomic indices, such as similar income status and education status. Dr. Komoromy also noted that Hispanic-American and African-American physicians were more likely to establish practices in such communities with high percentages of minority citizens. Thus, part of the answer for greater access to healthcare for the nation's minority populations is an increase in the number of physicians from those groups.

A report released in May of 1999 in Washington D.C. by the Public Health Policy Advisory Board revealed that our nation is not addressing some of the prominent health issues confronting our children today. Those are primarily deaths from injuries, homicides, and suicides. The title of this report is *Health and the American Child, Risks, Trends and Priorities for the 21st Century*.² This report is a result of a year long project and is the most comprehensive study of its kind. While many causes of childhood death are on the decline, the report finds alarming gaps in the progress of addressing other important and many preventable threats that claim the lives of children today. Adolescent suicides and homicides have increased dramatically in the past few decades and now represent the number two and number three causes of death in children between the ages of one through nineteen. Indeed, the report found that the top three causes of death in the age group one through nineteen years are unintentional injury, comprising 43% of the deaths; homicide, comprising 12% of deaths; and suicide comprising some

2. *Health and the American Child, Risks, Trends and Priorities for the 21st Century* at <http://www.phpab.org/healthandtheAmericanChild/ReportPortal.htm> (last visited Jan. 27, 2000).

6% of deaths. All three together accounted for 63% or almost two-thirds of all deaths in childhood.

In addition to identifying the leading causes of child mortality, the report provides an important analysis of risk factors underlying those causes of death, such as substance abuse and handgun violence. The report also examines how social factors such as poverty and family structure affect children's health. The report also provides broad recommendations to serve as a catalyst for developing a better national framework for protecting the health of our children. Presently our nation's policies and programs designed to protect children's health are not as affective as they should be because there is no comprehensive national strategy. The solutions to these causes are multifaceted. They include improved access to healthcare, which means more availability of health insurance to diminish the geographic, economic, and cultural barriers as well as the improved health behaviors of our citizens themselves. Sustained vigorous education efforts including health promotion and disease prevention programs are needed to address these problems.

B. Cures

A little more than a year ago, I was pleased to participate in the release of *Healthy People 2010* with the United States Public Health Surgeon General David Satcher. Also participating in the release of *Healthy People 2010*,³ was former Surgeon General Julius Richmond who served under President Carter and who released the first set of national health goals in the document called *Healthy People in 1979*.⁴ Having served as Secretary between 1989 and 1993, I released *Healthy People 2000*⁵ in September of 1990, which had some 298 health goals for the nation, which we hoped to reach during the decade of the 1990s. While our nation did make significant progress during the 1990s, including such gains as lowering infant mortality, increasing the rate of childhood immunizations, decreasing death rates

3. U.S. DEP'T OF HEALTH & HUMAN SERV., *Healthy People 2010: Understanding and Improving Health* (2d. ed. 2000) at <http://www.health.gov/healthypeople/Document/tableofcontents.htm>.

4. Public Health Service, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. Washington, D.C.: US Department of Health, Education, and Welfare, Public Health Service, 1979; DHEW publication no. (PHS)79-55071.

5. *Healthy People 2000*, at <http://www.odphp.osophs.dhhs.gov/pubs/hp2000> (last visited Jan. 27, 2002).

related to heart disease, cancer, and stroke, we actually lost ground in other areas such as obesity in children and in adults. In spite of these setbacks, overall, the Healthy People 2000 movement was a success during the decade of the 1990s. Our new national health goals articulated a year ago with the release of Healthy People 2010 include almost twice as many objectives; 467 as compared to 298 in 1990. The essential goals of Healthy People 2010 are two firsts: 1) the increase of quality and years of healthy life and 2) to eliminate disparities in health status.

During the twentieth century our nation experienced remarkable improvement in the health of our citizens. An infant born in 1900 had a life expectancy of forty-seven years, whereas, today, an infant born has a life expectancy of seventy-eight years. Almost a doubling of life expectancy occurred during the twentieth century. This was due to multiple factors including: improvements in public health such as the provisions of safe drinking water; the availability of nutritious food; and improved sanitation as well as advances in medical care. If you go to many developing countries you will find that safe water is still not readily available. These are the things that we take for granted in our society today.

In 1900, leading causes of death included pneumonia, tuberculosis, diarrhea in infants, and diphtheria. In contrast, today, the leading causes of death are such things as heart disease, our number one killer; cancer at number two; and stroke, number three. Chronic obstructive pulmonary disease, kidney failure, diabetes, AIDS, and violence are also leading causes of death. Upon review of the ten leading causes of death, disease, and disability today among our citizens, it is clear that our health behavior does play a significant role with our biology and with our environment.

1. Promoting Healthy Behaviors

Health behavior will be increasingly important going forward into the new century. Individually, and as a community, the decisions we make not only shape our lives but they expand or limit our freedoms. They also influence the lives of others, particularly our children. Working together as a community, a state, or a nation can create a culture of positive values and healthy behaviors. We can continue to improve the health of our citizens as we improve the living conditions in our society.

Now, improvements in life expectancy over a twenty-year period, from 1970–1990, were calculated by a group of independent economists headed by Hugo Sonnenschein of the University of Chicago. The improvements in life expectancy have been estimated independently by these six economists

at various academic institutions around the country to have added fifty-seven trillion dollars, to our nation's economy through this twenty-year period or an average of almost three trillion annually. This is a result of the prevention of illness and injury as well as improvements in healthcare. This report is titled *Exceptional Returns: The Economic Value of America's Investment in Medical Research*,⁶ published in 1999 by Hugo Sonnenschein and other economists.

2. More Research

The gap in health status between blacks and whites results in an estimated 73,000 excess deaths annually in the nation's African-American community. An effort to close the gaps in health status should reduce these excess deaths, as well as, result in significant economic returns as well, lower healthcare costs, increased wages, more tax revenues, and less demand for social services. This will result in a healthy working population as compared to a health-impaired disabled population. So, from an humanitarian perspective, as well as from an economic vantage point, efforts to address the disparities in health status and healthcare will show significant results for our society as a whole. We need more research into the underlying reasons for persistence of health disparities in our nation.

In 1989, an article in the *Chronicle of Higher Education* reported that less than 1% of grants from the National Institutes of Health, our public research agency, as part of the United States public health service, were awarded to minority scientists, whether those scientists were at minority or majority institutions. Ten years later in January of 1999, the Institute of Medicine found that the National Cancer Institute, the largest of our NIH with a three billion dollar budget funded studies specifically focused on the problems of cancer in the nation's minority populations, with grants of less than \$150 million dollars in a three billion dollar budget.

3. The Center for Research in Minority Health Disparities

I attended hearings before the Subcommittee on Health and Human Services of the United States Senate Appropriations Committee headed by Senator Arlen Specter. We proposed that greater attention and resources be

⁶ The report is available at <http://www.laskerfoundation.org/reports/pdf/exceptional.pdf> (last visited Jan. 27, 2002).

given in our nation to addressing the issue of health disparities. We recommended that the Office of Research in the Minority Populations of NIH be elevated to a Center for Research in Minority Health Disparities. Now the significance of that is as follows. First, a Center has direct grant making authority, which an Office does not have. Secondly, the director of a Center sits as a member of the policy-making body of the National Institutes of Health, which the director of an Office does not. Finally, the profile of the programs would be higher for a Center than an Office. Consequently, legislation was introduced and passed by the Congress to establish such a Center at the National Institutes of Health. That bill was signed into law in December of 2000 by President Clinton.⁷

The purpose of the Center is to develop and monitor the NIH strategic plan to increase funds for research programs focused on health disparities and minority health. Now this is an encouraging development, but the Senate is still young and it is still organizing its programs and its personnel. It is hoped that other health agencies in the United States Public Health Services such as, the Centers for Disease Control, the Health Resources and Services Administration, the Agency for Health Care Quality, and other public health agencies, as well as, state agencies and private research organizations, will join a comprehensive sustained effort to understand all the reasons for disparities in health status and in healthcare for our country. This should be coupled with the development of programs to eliminate these gaps in the health of our poor citizens and minority citizens. The benefits to our nation would be not only improved health but greater productivity from the work of citizens, resulting in a significant increase in our standard of living. It is primarily a question of political will and of commitment.

V. CONCLUSION

My hope is that our leaders and our citizens will provide that commitment for a greater, healthier nation in the new millennium. In the professions, we need you and your colleagues to provide your talents and your leadership skills and your commitment to helping solve these problems. Health is not simply a problem for health professionals. It is a problem for all of our citizens. The challenge is great but so are the rewards. Never has

7. Minority Health & Health Disparities Research and Education Act of 2000, S. 1880, 106 Cong. § 101 (2000).

the need, nor the promise, been greater for achieving significant changes to benefit those who have not been as well served by our system. I leave you with this challenge because it is an opportunity for leadership. Thank You.

VI. QUESTIONS AND ANSWERS

Professor Cerminara: Actually, if I may, take introduction prerogative and ask the first question. I am curious, with regard to access to care issues; it seems that we see a lot going on right now with the explosion of the Internet. We hear a lot of talk today about wireless technology and everybody being on the Internet. We see a lot going on with regard to consults over the Internet, medical records being shipped back and forth for information purposes. Just information becoming available on the Internet to anybody surfing around who can learn something about conditions, statistics, causes of death, possible stuff you could take to be in better health. Do you think that this increasing interaction of the Internet and medicine will help eliminate some healthcare disparities, or do you think it will perpetuate or deepen them?

Dr. Sullivan: Well, first of all, I think that there is no question that the Internet will contribute to improving the health of Americans. The challenge will be to see that it does not cause further widening of the divide between those that have and those that have not. There are many efforts under way around the country to be sure that we do not have that divide that widens. But I think the Internet certainly is playing a very positive roll, and it also fits with the fact that our citizens want to be more in charge of their health-care than previously.

I have lived long enough to go from the phase where the typical patient would say “well doctor you do what you think is best, etc.” So the patient would not even bother to understand what the problem was but simply put it into the hands of the doctor. It is very different now. People want to know what is wrong, what is the diagnosis, and what does this mean in terms of my health, my ability, my ability to work, life expectancy. What are the treatment options? I would like to get a second opinion. I want to know what are the side effects of this drug. So people are taking a much more active role and certainly the Internet helps that very much. And of course, typically a patient comes into the doctor’s office already with a huge print out about what the symptoms are. So, certainly that is a part of it.

I think that it is healthy and as I have mentioned, with the healthy people movement, this is a process that does require it to be effective, active

participation by individuals themselves in preserving and affecting their health. There is more change in the profile of diseases that Americans are dying from today versus one hundred years ago. Many diseases are chronic conditions, which are affected by lifestyles, such as heart disease, our number one killer.

We have a little more than two million deaths a year, and of those, roughly three quarters of a million or 750,000 are related to heart disease. Well, heart disease is related to whether or not you are overweight, whether or not you exercise. Studies have shown repeatedly that people who are active, whether it is simply walking or playing tennis, or golf, or doing aerobics, those people have lower incidents of heart attack or stroke. They live longer; if they have high blood pressure, their blood pressure tends to come down. They may eliminate the need for medicine entirely.

So those are things that the patients themselves can do. People who are well educated or have access to the Internet can get that information. So clearly, it will have an overall positive affect. The problem that we have to address is making sure that everyone does have access to the Internet because those who do not could be left behind.

Student: Dr. Sullivan, can you tell us which specific causes of mortality have the largest discrepancy between black and white populations?

Dr. Sullivan: Well there are several. For example, deaths from stroke, for example, among African-Americans are twice as high as among Whites. Infant mortality again is twice as high. As you look at the various populations, you see other discrepancies. For example, deaths from diabetes are up one and a half times as high in African-Americans. But they are about five and six times as high among the Pima Indians of Arizona as among Whites. They are being investigated there because we do not understand all of the reasons why they are showing a higher incidence. Diabetes is one of those conditions that has an underlying genetic propensity. It tends to run in families, but it does not mean that if you have that tendency, you will develop diabetes. I am sure many of you know people who may be in their 40s or 50s and suddenly found that they have diabetes. They may have gained weight, or other risk factors may have developed. So, there are a number of other environmental factors that influence whether or not they indeed become overweight, which may bring out the diabetes tendency. Vietnamese women have a high incidence of cervical cancer compared to Whites. So there are a number of specific discrepancies when you look at different populations. However, the major discrepancies based upon size of the

population is between the African-American community and the White community.

Perhaps the worst discrepancies overall are really among the Native-American population. We do not have good data there. That is, we have enough data to know, but the data we do have is not as voluminous or as precise as that of the African-American population. Again, heart disease, stroke, and infant mortality are the greatest discrepancies.

Interestingly enough, when you look at such things as breast cancer you find that the rate of the incidence of breast cancer is about the same between African-American women versus white women. Nevertheless, deaths from breast cancer are higher; about 40% higher among black women. It is thought to be an access to care issue including the lack of health insurance.

It also can mean the attitudes of individuals. That is if you wait, if you do not come in early when you have a lump, discharge from the nipple, or other signs, and you come in six to nine months later, well you may have a disease that has progressed much further. Individuals need to be aware of the advantages that can accrue to them by early medical care and not ignoring a problem. Again, that is part of the individual's attitude. Does the health system benefit them? Because again, I maintain that the health transaction is a scientifically based but socially influenced transaction. The biology is there, but it depends on how the interaction occurs and of course the other thing that I mentioned, is that some of the unconscious bias that studies have shown in how patients are treated when payment for services is not an issue.

The Medicare studies and the Veteran studies of diabetic of black veterans with vascular problems in their legs, because vascular problems are common in diabetes, show that more had amputations rather than arterial grafts. Here again, we do not know how much of this is the attitude of the patient or the patient may just feel that the best thing is to get rid of the leg, where you have circulatory problems versus how much advocacy the health professional gives, in terms of arterial grafts.

Student: Regarding your comments about economics and insurance. Do you have any thoughts about the evolution of managed care in the last ten years and any predictions about where the American insurance system is going; more regulation or maybe more public sectors, or is the public sector thing really "in the tank" after Clinton's initiatives?

Dr. Sullivan: Well, first as you know, we have a public/private healthcare system. Where the care is provided by public insurance such as Medicare

and Medicaid, a federal/state system. The other 60% is really primarily private sector employer-based insurance. In the end, the costs are quite significant. I should have made one other comment too about the Internet: one of the real challenges right now are the so-called Health Insurance Affordability Act Provisions of 1996,⁸ the Kennedy-Kassenbaum Act.

One of the requirements is that before information can be released we have to have the permission of the patient. Moreover, the question is what does that mean. Someone predicted that means that even getting a prescription filled is transferring information. What is consent? What does consent mean? In addition, the other thing is carrying on a number of clinical trials, which have been helpful in giving us better treatment.

There are a number of treatment protocols that are going around the country whether it is cancer or heart disease or diabetes or a number of things. You really have to collect a lot of information and sort it out. How do we do that while we protect patient confidentiality? If you are a physician and you are referring a patient to someone else for a consultation, does it mean you have to have written permission of the patient? So in other words, these are the regulations that go into effect at the end of this month that many in the health industry have asked that they be delayed, because of the complexity of them and adding to cost of the healthcare transaction.

We just spent \$1.2 trillion dollars or almost 14% of the GNP last year on healthcare. People are saying: well this could really cause glitches in provision of care but send cost up tremendously. There is conflict here. How do we really provide security? Everyone agrees that no one should be compromised by learning that you have a tendency for diabetes. But how do we do this without interfering with the provision of care and without adding to the cost?

The other thing I should like to mention is we have 14% of GNP healthcare now; the percentage of GNP that the healthcare consumed in 1960 was 5.6%, so this is threefold and this is the very time that our economy has expanded. And that is an issue.

Now, on the issue of managed care I think that, first of all, managed care has contributed to our ability to control cost because in 1989 when I went to Washington it was predicted then that the healthcare system would consume 18%, even 20% of the GNP by the year 2000 if we did not bring cost under control. Well, we are at 14% now rather than at eighteen, perhaps

8. The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, (previously H.R. 3103).

even 20%. The significant part of that has been the contribution of managed care. However, managed care assistance are like anything else we have, it is like the differences in your choice of automobile mechanics. Some are very good and others you would not go to again.

Some of the managed care programs have been very restricted and more focused on cost containment rather than provision of quality services. There has been a backlash against a number of managed care programs. We have some loosening of programs, of greater growth of what we call point of service programs or PPO programs as opposed to strict managed care operations.

I think that we are going to see continued efforts, though more modest ones, than the Clinton effort to provide reform of the healthcare system. I think the Clinton effort fell of its own enormity, but that was not the only problem. Politically, I think, a serious mistake was made. As you try to reform a system that has a lot of moving parts, a lot of very bright people with dedicated constituencies and what happened with release of the plan by President Clinton was: the hospital industry was attacked; physicians were attacked as being greedy, insurance companies were attacked, and the pharmaceutical industry was also attacked. Furthermore, there was this "five hundred person secret committee," which how can you, in Washington you cannot have a secret committee of three people let alone five hundred. The AMA for example was not invited, was not included. So it created a very powerful collection of adversaries.

In my view it would have been much smarter to bring everyone in and to debate the issues out here and perhaps they would have ended up with a less sweeping effort, but I maintain that with a more modest effort we would have succeeded. That would have put us in better shape today than we are. So, that was the problem. Such things as the Children's Health Insurance Program that has been implemented is still not working as well as it should. The prescription drug debate that is well under way now is for our seniors.

Student: Do you think that we are going to get one this year?

Dr. Sullivan: I would not bet on it. No, it may happen but I think I am not seeing a galvanized effort to really bring that together yet. Because first of all, it is defined differently by different groups; as you know President Bush had a more modest prescription drug plan than some of the Democrats would want. So, with Congress being virtually evenly divided, still its slightly Republicans and Republican President the last thing that Congress wants to do would be to override the President. The chances are, we are going to get

a modest bill or not one at all. The key thing that existed in 1993, was a general agreement with the public that we had a system that needed to be fixed. We still have a lot of understanding there but not the level of public agreement that we really needed to bring this about. So I think there will be incremental changes here and again. Continued efforts like the Health Insurance Affordability Act is designed not only to enhance the transaction but also, by use of Internet and electronic systems, to reduce the cost of the healthcare transaction. It is predicted, with full implementation of electronic commerce, that over a period of four or five years we could save at least forty-five billion dollars in administrative costs because of the cost of paperwork. Therefore, I think that we are going to continue to see modest efforts tinkering with the system. But I predict that it is going to be perhaps two to three years or more before we see enough dissatisfaction to really provide a political imperative for significant change. Hopefully, those efforts will actually include the major players in the healthcare system, as opposed to exclude.

Student: As far as the economic position of specific minorities, are they affected by their ability to have access to higher levels of insurance with our managed care system the way it is, and is that possibly the responsibility for the disparity of the longevity between minority group and the Whites? And if so, do minorities or anybody in general have rights to the same quality care? And if so, do you foresee some kind of solution for the systems that equalize that?

Dr. Sullivan: Well, first of all, so far as the lack of health insurance, it does affect different groups differentially. Around 13% of the White population is uninsured. 21% of African-Americans and 31% of the Latino population lack health insurance. The absence of health insurance does not include the percentage of people that are underinsured, they have an insurance policy but really, it is very limited in what is actually provided. Another factor is that our private system is based primarily on employer-based insurance. Therefore, the unemployment rate affects our health insurance rates as well.

It is very expensive to have an individually purchased health insurance policy, about 40% of what you pay in premiums are administrative costs. Those are the two main contributing factors. A third factor involves choices influenced by economics. The choice between paying for health insurance or providing food and clothing for their children. I think that clearly, the solution in my view is going to be a public and private system, and that is to

really help provide for poor people or low-income people in purchasing health insurance.

In fact, during the first Bush Administration, we proposed a bill that would have provided for people with low income levels, that is incomes up to 200 percent of the poverty level would receive a voucher provided by the taxpayers for purchase of health insurance. Today that voucher would have been worth \$3750 a year. However, it was criticized for being insufficient. Some felt that it should probably be about a thousand dollars higher or more. That was during a time when there was a Republican President with a Democratic Congress. It was introduced in February of 1992 and we could not get congressional hearings that year. That was an election year, and if you have the White House and the Congress in different parties, from a political standpoint, you do not want to provide the other party with potential issues with which they could win. In other words, the timing for the introduction of that legislation was not good because we were getting into an election season.

That bill would have provided help towards health insurance and it had features in it that we estimated at that time, if enacted, the bill would have reduced the number of people without health insurance from thirty-seven million to between five and seven million. It was not perfect because there still would have been a significant number of people without health insurance. But we reason that the system would have been able to absorb that level of citizens without health insurance because right now in public hospitals, perhaps as many as 50% of the people seen at a hospital, like Jackson Memorial Hospital, are uninsured. Which means that Jackson Memorial and the taxpayers of Dade County are providing the dollars to pay for healthcare in less than ideal circumstances; people are having long waits, or missed appointments because again people do not have a quote, "friendly encounter" with the healthcare system. They come in and have to sit around and wait for hours and a lot of other things that happen to them.

I think that we will see a resurrection of some features, like the development of group purchasing cooperatives for health insurance, particularly for small businesses. A reason for this is that most of the people without health insurance are those in small businesses, because the cost of insurance in small businesses represents a greater cost than in larger groups. But in some parts of the country where you have group purchasing cooperatives, that has brought down the cost of insurance because you have a larger pool over which you spread your risk, and your administrative costs also come down on a per capita bases as a group gets larger.

Student: You mentioned the constitutional institutionalized legalities of young slaves being educated, and as a result we have fewer professionals out there than otherwise. Can you give me some numbers on African-Americans and other minorities being actively involved in a study program. And do you believe that the Tuskegee study may have made an impact on their participation.

Dr. Sullivan: Yes, clearly the Tuskegee study has had a negative impact that continues today. And for those who may not be familiar, the Tuskegee study was a study that was started back in the 1930s looking at the natural history of syphilis in black men in Tuskegee, Alabama, because in the 1930s there was no treatment for syphilis. Penicillin was introduced in 1941 and cured syphilis. But, in spite of that, the study was continued until 1972. When it was reported there was outrage. This was a study conducted with support from the United States government. This has had a profound impact on the level of trust that African-Americans and some others have on the healthcare system. That is, am I going to be experimented on? If I go there, will I be given the best treatment? So yes, there is a wariness.

Pharmaceutical companies today, for example, are really pressed very hard by the Food and Drug Administration ("FDA") to have a diverse population group to test new therapies, and among those groups, they include a significant number of minorities. The similar thing, but for different reasons, exists for women in studies. Women were excluded from clinical trials over the years for a number of different reasons. Primarily, one being that if a woman is pregnant she is unaware the experimental protocol that may do damage to the baby. Similar things for children, because of their rapid growth, accelerated metabolism, they were often not used for studies.

So even today, a lot of the drugs we use in children we have extrapolated our understanding of the drug from the use of adults to children. But the FDA now has over the last decade or so, changed that to say if the drug is going to be used in children or women, it should be tested in them. So there is a very different environment now for clinical testing of drugs.

But coming back to the African-American population, it is because of that as well as other encounters that African-Americans have had with the system that would account for their unpleasant view or distrust of the health professional. There is a great difficulty now in getting a significant number of African-Americans enrolled in clinical trials and that raises an ongoing problem.

Professor Cerminara: Thank you very much Dr. Sullivan.