

Conversation with New York's health commissioner

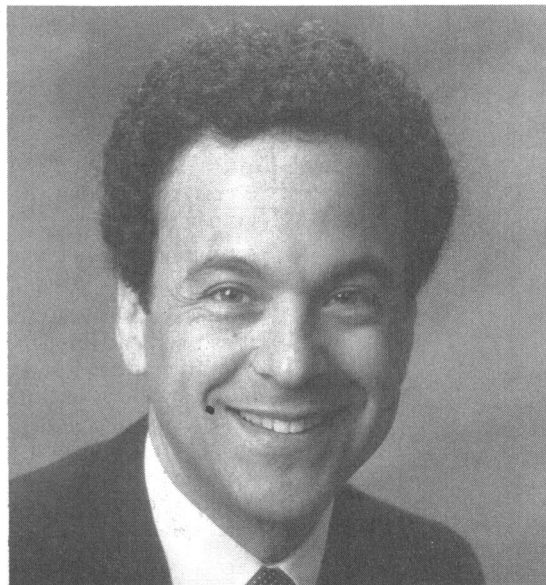
Fred B Charatan

On 1 July 1992 Mark R Chassin took up the post of health commissioner of New York state. I spoke to him about New York's health problems and his plans for solving them.

Background

Dr Chassin is a native New Yorker and a third generation physician. Both his grandfather and uncle were general practitioners, and his father was a surgeon. He received his MD from Harvard in 1973 and also holds masters degrees in public policy from Harvard and in public health from the University of California, Los Angeles. He served his medical internship and residency at Harbor General Hospital, a public hospital in Los Angeles. Board certified in internal medicine, Dr Chassin practised emergency medicine for 12 years. Dr Chassin told the New York Senate committee which confirmed him, "Sooner, or more often later, every significant public health issue shows up in the emergency department."

He worked at the health care financing administration in Washington, DC, as deputy and then medical director of the Professional Standards Review Organi-



Mark R Chassin, New York's health commissioner

NYS DEPARTMENT OF HEALTH

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zation. In 1979 this organisation represented the federal government's first nationwide attempt to build quality assurance and cost containment into the Medicare programme. Dr Chassin was a senior project director for the Rand Corporation, where he spent nine years performing and administering large health policy research projects designed to study the quality and costs of health care. In one milestone study, Rand researchers found that three common procedures—carotid endarterectomy, gastrointestinal endoscopy, and coronary angiography—were often performed without sufficient clinical justification.

For the four years before being nominated as health commissioner Dr Chassin was senior vice president of Value Health Sciences in Santa Monica, California, a health services research and consulting firm that develops guidelines and software for health care quality assurance and reviewing use of services.

Access to care

FC: I'd like to cover some of the more important topics pertaining to health in New York. The first topic is improving access to health care. I don't know how many of New York's 17 million people have no health insurance, but it must be proportionately similar to that throughout the United States.

MRC: It's actually a bit lower—about 2.2 million are uninsured. Most of those who are uninsured are working. In some areas 80% of the population who are working don't have access to health insurance. It's a major problem. It's compounded by inadequate insurance. If you take that into account nearly four million people have no insurance or are underinsured. Lack of access to health care is a major priority of the department of health.

FC: Are there other reasons for lack of access?

MRC: Yes. There is also lack of availability of continuing primary care, even for those who have health insurance. It's a problem for the people eligible for Medicaid (state supported health care for the under 65 population below the poverty line; Medicaid patients

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are not accepted by many physicians) but also for those who are not eligible. We've got the wrong balance in the state—in the country as well—between specialties and primary care. Most physicians who practise in New York state are specialists; 80% of the doctors who practise in New York are trained in New York. So the lack of primary care directly reflects the balance in the training of specialists and primary care physicians. It leads to other problems in misuse. We need to begin to address the balance to get a more equitable and credible pattern of health care. The goal of universal



DIDIER RUEF/NETWORK

*About 2.2 million are uninsured
—lack of access is a priority*

access to continuous primary care is one we have to keep in front of our planning.

FC: But how can you achieve that goal?

MRC: There are any number of models by which that goal can be achieved. That's not a conceptual problem. It can be done through any of the major health care reform strategies—a single payer system, a national health system as in Britain, private pay, or any of the varieties of universal health care we haven't talked about yet. The reason we haven't got there, that we haven't chosen anything, I believe, is the failure of all of those strategies to deal with the problem of cost. That's another priority of the department.

Controlling costs

FC: Well, you have been a leader in that.

MRC: We've proposed some strategies that I think could be effective. Our first responsibility in regard to cost is to attack the problem of overuse, because that will allow us to improve quality and to control costs at the same time. With all the overuse in the system I think it is irresponsible to propose explicit rationing—that is, to say formally that we will not provide necessary and effective care under some circumstances, simply because we cannot afford it. If we don't address the problem of overuse, we will not only be missing a major opportunity to control costs but a major opportunity to improve quality. And that's where I think our principal cost containment efforts ought to be focused.

FC: How would you analyse further the problem of cost control?

MRC: I see the problem of cost control in three dimensions. Overuse is one. Efficiency is another. You can define that as producing the same things we do now, but with a lower use of resources at less cost. And there's a lot of opportunity for that. We have failed to bring physicians into the process of making hospital care more efficient. We've seen fairly substantial decreases in length of stay in hospital with the advent of prospective per case reimbursement in this country. Surprisingly, reductions in length of stay have occurred in parallel in areas like the northeast, which started out with the longest stay in the country, and the west, which started out with the shortest. Nobody thought that the length of stay in the west could get shorter.

Physicians must assess practice

Any further gains in efficiency will have to come from physicians looking at their own practices and

starting to compare them with practices in other institutions. It's very unusual, for example, for a group of surgeons from the northeast to sit down with a group from the west and ask, Why is the postoperative length of stay for a laminectomy 10 days in New York and only five days in Los Angeles? What are we doing differently? What are we doing differently intraoperatively? When do we start feeding patients? How quickly do we get them up and walking? What are the specific processes of care that are different in the two places? Can we get some agreement on what optimal practices ought to be? And is there any harm we're doing by the short length of stay in the west? If there isn't—and a study 10 years ago showed no evidence that outcomes were affected by variations in length of stay—then some of these shorter stay, more efficient practices could be imported.

Hospitals in New York already have the financial incentives to examine practice and decrease length of stay because they get per case payment for all patients, not just Medicare patients. Why haven't we done it? Well, it's the inertia in the medical community, I believe, in bringing physicians into those management decisions, the lack of a facilitator to get some of those practices looked at in detail. And I think the state health department can be a facilitator. So that's the second component, efficiency, and we've got a long way to go before we conclude that we can't make health care more efficient.

I just visited a hospital in Texas that had started a continuous improvement programme among its medical staff. The hospital had looked at the care of patients who had cataracts removed and intraocular lenses inserted and found a high variability in costs among cases. Investigation showed that one of the reasons—in fact the main reason—for the variability in costs was that each of the six or seven ophthalmologists doing the procedure in the hospital had a different, favourite intraocular lens. And the price varied between \$600 and \$3000. Nobody had ever sat down and asked why these different lenses were chosen. The answer was that the choice of lens depended on the company representative that had visited the surgeon.

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The surgeons concluded that there were no differences in outcomes, utility, or longevity among the lenses. They got the department to agree to go with one of the cheaper lenses and saved a quarter million dollars. It's that kind of involvement of physicians in practice decisions that offers the greatest opportunity to increase efficiency.

Assuring appropriate use

FC: You're really talking about getting practice guidelines accepted, then?

MRC: Yes, that is another way to achieve a lot of goals, not just efficiency. Practice guidelines can work to solve problems of underuse also. I would identify the practice guideline movement in a broader context of quality improvement.

But let me finish the question of cost. The third area of cost is in the area of new technologies, new procedures, new drugs, new treatments—anything that's new. We have done a particularly miserable job

in this country of assessing the effectiveness of new procedures and new technologies and limiting their use to proved, effective indications. No plan that I've seen, whether it's state or national, deals effectively with this problem. But if we don't deal with this problem all other efforts at cost containment will be blown up within a few years. It seems to me that there are too many examples of wonderful, marvellous new technologies whose effectiveness has been shown for a narrowly circumscribed group of patients which then get out into the world and get used not only for that group of patients, but for hundreds and thousands of other patients for whom its usefulness has not been shown. That is a big, ongoing problem, and it's something we need to tackle as a nation, to tackle directly, because, as I say, it will defeat or certainly mitigate the effectiveness of other cost containment efforts.

Practice guidelines, to get back to that, I see in a much broader context of continuing quality care. How do we get the most energy, devoted the most effectively, to continuously improving quality care? And fundamentally, I believe, that is achieved best when the individuals, the institutions, the medical groups delivering the care are engaged in self examination and quality improvement. And I think the whole effort to measure and assess and assure quality has undergone metamorphosis. Over the past 25 years many requirements have been layered on to the medical community. Doctors, in particular, are justifiably sceptical about this new label (quality assurance) because they haven't seen much change, they haven't seen much in the quality measurement movement that has helped them take care of patients better. After all, that's what physicians are most concerned about.

I think practice guidelines mean a radically different approach to the whole problem of quality. Quality, along with access, cost, and public health epidemics, is right up there as a major focus for a lot of reasons. One reason is that the ongoing, debilitating documentation of quality problem after quality problem—whether it's in hospitals in New York, whether it's individual physicians who are practising egregiously outside the boundaries of acceptable care—is one of the main contributors to the loss of public confidence in the health care system. That needs to be repaired. Poor quality has several other implications, quite apart from

the fact that quality problems burden patients with harm.

Improving quality

FC: How do you see continuous quality improvement developing in the future? What should doctors be doing?

MRC: There are three kinds of quality problems—overuse, underuse, and misuse. I wrote an editorial on this for *JAMA* last December.¹ We've talked about overuse, and I think that needs to be a major focus for us because of the quality and cost implications. The government, the medical profession, and even hospitals have tended to use quality control as a punitive mechanism, defining mistakes that individuals have made to find opportunities to blame people and then use the quality assurance system as the means to punish them. I don't think that's very effective. A regulatory or punitive option is necessary because there clearly are physicians, nurses, hospitals, and nursing homes who can't or won't improve the quality of care they provide. The punitive option ought to be the one of last resort in my view. I think that the best way to improve quality is by getting those who are delivering the care to participate in the process of quality improvement.

That's why this notion is radically different from what's been done over the past 25 years. The first departure is that continuous improvement envisions the perpetual process of self examination and self improvement. It envisions the idea that if your goal is to improve the outcomes for patients, what you ought to be doing on a routine basis is asking, How should we be dealing with this particular clinical problem? How should we be taking care of patients with urinary tract infections? How should we be taking care of patients we admit with uncomplicated myocardial infarction? What do we know from the literature about what works and what doesn't work in these situations?

Guidelines

The notion of guidelines is not really new. I have found some 5000 year old ones from Assyria. My favourites include a treatment for chronic bronchitis, which involved inhalation therapy, and a whole prescription for a series of treatments with beer, which are probably as practical as what we do now. The first step is a process of setting down quite explicitly what we believe constitutes best practice. The second step is to look and see how well we're doing with respect to those guidelines, in achieving what we think is best practice. Discrepancies are assessed and if there's a problem it's corrected. Maybe the problem was we didn't specify the best practice, so we need to revise the guidelines. So it becomes an ongoing process. It's not a one time audit that you do and put aside and forget about. It becomes incorporated in the way you practise, and that, I think, is the radical departure, because it's intended not only to be a method that is incorporated into daily practice but a method that really helps to protect patients.

What I hope to do is move away from quality improvement as a punitive process, away from external regulation, external controls, and inspections, to an internal process which results in a collaborative relationship with the health department. The department's role should be what we can do best—that is, to collect data and feed it back to hospitals. Hospitals and physicians can look at their own practices but they won't have much of an idea where they stand with respect to their peers. We can provide that information and also facilitate the sharing of best practices. For example, we have a state of the art data set on the



BRENDA PRINCE/FORMAT

Use of new technology is often extended to purposes where benefit is not yet proved

outcomes from cardiac surgery. It's better than any research data set in the nation. What we don't yet have is a good understanding of what produces the enormous variability in risk adjusted mortality among hospitals. We need to understand it. The health department ought to be facilitating institutions to look at each other's processes of care, so that we can start to understand what is producing these very different outcomes—again, with the goal being not to punish but to share best practices among institutions so that everybody's quality is improved. The maxim is "continuous improvement." If you look at quality as some sort of normal distribution, then trying to chop off the worst end of the spectrum doesn't move the average quality up very much. You get a greater improvement by trying to push everybody's quality to a new and higher level. And that's what I think we ought to be about.

Epidemics in New York

FC: Let's now talk about some of the epidemic diseases facing New Yorkers.

MRC: Epidemics are clearly important for us. And there are a lot of them—HIV, tuberculosis, measles, syphilis, and also rabies. To give you some idea of how rapidly

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rabies is spreading, in 1989 there was not a single case of documented rabies in a terrestrial animal in New York state, although some bats were infected (rabies is enzootic in bats). That year only 81 humans were given prophylaxis after exposure to bats or animals outside the state. In 1991, two years later, the number of humans given prophylaxis had risen to 967. And this year we're on a pace to exceed that by about two thirds. It's a complicated problem because local county health departments and county governments must pass their own legislation requiring dogs to be vaccinated. The law requires cats to be vaccinated in any county where rabies has been shown in a terrestrial animal, so that is moving along. We had a big meeting last week where we brought in all the county officials who were not yet picking up stuff and we presented this information, presented the urgency. The press has been pretty good about picking up this story, though it tends to view it from the human standpoint, and I hope that it will not take a case of human rabies to prevent an epidemic—to get people to leave wild animals alone and get pets vaccinated; pets are the principal barriers between wild animals and us.

HIV and tuberculosis are two of the most important menaces we face. HIV is one of the reasons we have seen a resurgence of tuberculosis. If you look at the case incidence of tuberculosis in this country, it's almost a straight line down from the 1800s until eight or nine years ago when it started to back up. And the bulk of the fall occurred long before there was any effective treatment for tuberculosis. One of the major reasons we're seeing a recurrence of tuberculosis now is that we're recreating the same social conditions that allowed it to flourish at the beginning of the century—substandard overcrowded housing, poverty, lack of nutrition, homelessness. All of these social problems have contributed to the resurgence. HIV clearly is a new factor. It has created a vulnerable population, and

drug addiction is spreading another vulnerable population. But treating tuberculosis as purely a medical problem, even as a public health problem, is not broad enough. We're not going to be able to eradicate this disease, even if we pour all the public health resources into controlling it, unless we correct the underlying social and economic causes.

Improving relations

FC: How do you plan to improve relations between the health department and New York's 37 000 physicians? Do you plan to address the annual convention of the Medical Society of the State of New York?

MRC: That's very high on my list of goals, to reduce the adversarial relation between the health department and New York's physicians, hospitals, nursing homes, home health institutions—the list is rather long! I can't say whether I've received an invitation to the annual convention as I've received so many invitations to speak. I think that a number of the things we were talking about earlier are the vehicles for improving relations. I hope that the department will become less focused on the punitive application of regulations and much more focused on the technical assistance, facilitation, and encouragement of positive incentives to improve quality. This will, I think, not only make more pleasant relations but also improve quality of care more effectively.

FC: What has been the impact of New York's budget shortfall on the health department?

MRC: Very severe. I think that the process has been fair, in that the pain has been shared around various departments in the state. But we face probably another year, or maybe two, of very restricted budgets. It's impaired our ability to fund immunisation programmes; it's impaired our ability to help localities, including New York City, to fund tuberculosis programmes. Service programmes for populations with HIV that we would like to expand have been impaired. At almost every level we face the inability to deal with these pressing problems with sufficient resources. I think it's even more incumbent on us in this environment to make sure that our efforts are not impeded by jurisdictional squabbles, by the friction that comes when you've got several different sources of funds—private, federal, state, local, county. The different sources have an impact on a problem but are not coordinated in any way and not streamlined. We need to ensure that the resources get to the people who need the services in the most effective way possible. So I'm trying to work out relationships with the city health department, with the Centers for Disease Control, with all the major funding and provider organisations, so that we lose as little as possible of the resources as we go from funding source to the actual delivery source.

Change of government

FC: In view of a possible change of administration in Washington this November (a Democratic president) how do you think this would affect health care delivery in New York? Do you have any contingency plans to take advantage of such a possibility and the more favourable climate for social programmes likely to follow?

MRC: There's clearly a long wish list we would have. Several programmes have been cut back over the past 10 or 12 years that we'd like to see restored. Some of the funding mechanisms are still in place—the block grant funding mechanisms to pay for immunisations, other prevention activities, and maternal and child health.

It took legislation last year. The state legislature

passed a child health insurance bill, and we had to stop enrolling children because we ran out of money. It was only at the very last moment, at this last special legislative session, through extraordinary efforts by some really committed folks in the governor's office, that a deal was struck to expand the programme so we could reopen enrolment. The programme provides subsidised health insurance to children who do not qualify for Medicaid for primary ambulatory care—not hospital care, no medications, no high-tech procedures, just basic routine care, getting the infection treated before it turns into a major problem. It's a very narrow, circumscribed programme. But we need to expand it to all eligible children. The legislators chose children because frankly, from a political standpoint, children are easiest to sell. But as we discussed, there's so much need for expanded access to programmes like this, even before we get to comprehensive reform. It can be effective, I think, in targeting the most needy popu-

lations and solving some of the biggest inequities in the system. So I think we can push ahead with things like insurance reform as we did in this legislative session—community rating, eliminating pre-existing conditions. We can push ahead with patchwork programmes like child health. Any amount of resources we can commit to that while we're trying to deal with the larger issues—how we're going to control costs in the major programmes and expand access and make sure that quality doesn't suffer at the same time. We have to do both.

So I'd look forward to a lot of beneficial changes. I'd look forward to a more enlightened AIDS policy if we get a change of administration in Washington. I would hope even if we don't get a change of administration we would get a more enlightened AIDS policy, but I don't really see much prospect of that.

1 Chassin MR. Quality of care: time to act. *JAMA* 1991;266:472-3.

Confounding in epidemiological studies: why "independent" effects may not be all they seem

George Davey Smith, Andrew N Phillips

Nobody mentions that the children of parents conscientious and careful enough to have their children "immunized" will come out of any statistical test better than the children of the comparatively careless. Poverty, too, produces startling vital statistics which can be turned to account by the exploiters of any nostrum. If the jewellers had thought of claiming that the possession of a gold watch and chain is an infallible prophylactic against smallpox, their statistics would have been quite as convincing as those of the vaccinists.¹

In this quote George Bernard Shaw deals with an issue central to the interpretation of epidemiological studies: how is it possible to decide whether a factor is causally related to a health outcome, rather than simply being associated with factors which are truly causal? In epidemiological parlance, the issue at stake is that of confounding. This is illustrated in figure 1. Imagine that exposure A refers to smoking and exposure B to yellow fingers and the outcome is lung cancer. Through being associated with smoking, yellow fingers will be related to lung cancer risk. In this case interpretation is easy, yet how in general do we separate such spurious associations from ones that might be causal?

The issue is of more than parochial interest, since general medical journals devote much of their space to publishing the results of observational epidemiological studies that examine whether there are health risks associated with a particular exposure. It is not sur-

prising, perhaps, that these reports attract considerable media attention—especially when they show apparent hazards consequent on aspects of daily life.² Lately, for example, we have read that oral contraceptives facilitate the acquisition of HIV infection³; that coronary heart disease risk seems to be increased by drinking coffee,⁴ not drinking alcohol,⁵ allowing your teeth to rot⁶ or having had a low birth weight⁷; that sloth predisposes to diabetes,⁸ that not having received breast milk results in low intelligence,⁹ and that smoking is a cause of cervical cancer.¹⁰ Regarding the first of these apparently hazardous activities, however, a different group of investigators have more recently informed us that use of oral contraceptives, far from facilitating transmission of HIV, actually protects against the virus.¹¹ In this article we suggest that the phenomena bringing about these contradictory findings may distort many of the epidemiological associations that have created excitement regarding the possible identification of factors involved in disease aetiology.

Confounding in practice

Epidemiological studies of cervical cancer have, over the years, identified a myriad of risk factors for the disease; these have included not eating carrots, a history of induced abortion, drinking alcohol, practising masturbation at an early age, low dietary intake of folate, use of oral contraceptives, and high parity. That a sexually transmissible agent is involved is now generally accepted, but much attention has also been given to cigarette smoking, with a large series of studies having reported that smoking is associated with the risk of cervical cancer.¹²

If smoking is related to the risk of exposure to the sexually transmissible agent, then the association between smoking and cervical cancer could be due to confounding by this agent: following the scheme of the figure, exposure A would be the sexually transmitted agent and exposure B would be cigarette smoking. Much data indicate that this possibility should be taken seriously. Cigarette smoking is, for example, strongly associated (odds ratio of 7.2) with early loss of

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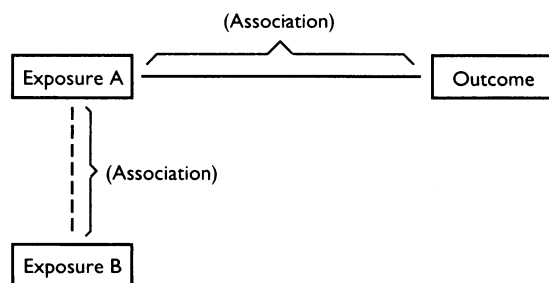


FIG 1—Exposure A (for example, smoking) is associated with the outcome (lung cancer risk); exposure B (yellow fingers) is associated with exposure A—and hence to the outcome