1995 Presidential Address

Public Health: Vision and Reality

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I want to express my appreciation to you for allowing me to represent this Association and to serve you as your President. It has been a demanding role, one with many challenges and satisfactions.

Any success which may have been achieved along the way was only possible through the aid and support of many others. Notable among them are the county of Los Angeles, the Department of Health Services, my staff (my reliance upon them was fundamental to my ability to represent you), the staff and executives of APHA (excellent and supportive), the membership and component elements of this Association (especially the affiliates who welcomed me to their meetings and their homes, who sent me letters, faxes, e-mail, and who telephoned), and all of you who took the time to speak to me personally. All the expressions of advice and encouragement gave me strength and great reward.

I am particularly pleased to represent you as a practitioner of public health, responsible for practical decision making, working within the realm of political reality, budget austerity, community partnerships, and public accountability. Consequently, I have brought to this task a sense of what makes public health relevant to the lives of people and the interests of the communities we serve. In that context, I salute all the public health workers, especially the road warriors of public health, the public health practitioners—your recognition is less than you deserve and far less than you have earned. You know the realities of public health, and you maintain the vision as well. You know what T. S. Elliot implied when he wrote, "Between the ideal and the reality, lies the shadow."

To represent you has been a singular honor. I have represented you at the White House and with representatives of President Clinton's administration, in offices of Congress, in the media, and among kindred organizations. In representing you, I have kept in mind a brief story with a point of relevance to this great Association. In the early days of aviation, the Vultee airplane was popular among a unique and dedicated group of enthusiasts. The plane had a characteristic vibration that some found uncomfortable, but which loyalists accepted as a characteristic of distinction that accompanied their pride of ownership. Consequently, the popular description of the aircraft was "30 000 rivets flying in loose formation"; and sometimes it appears that we in APHA are 30 000 members, each with riveted interests, flying in loose formation. But fly we do, and progress we make.

It is not news to you that public health is today pressured unlike any time in the past. Whether we like it or not, the current reality is that public health workers are viewed by many as representing big government run amok. Many of our services—Special Supplemental Food Program for Women, Infants, and Children (WIC), prenatal, health education, for example—are seen as unnecessary and unproductive benefits for undeserving populations.

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This Presidential Address was presented on October 30, 1995, during the Opening General Session of the 123rd Annual Meeting of the American Public Health Association in San Diego, Calif.

Part of the problem we face is a hardened America, with a viewpoint encompassing a mean-spirited, begrudging attitude towards social justice, affirmative action, equity, and compassion. California—the Ellis Island of America—embarrassed most of us by the passage of Proposition 187 and its "leadership" of this movement. For many, we in this room and the services we represent are seen as illustrative of the problem but not relevant to the solution. What we see as government in action, others see as government inaction. Where government is in action, some argue for government passivity.

Public health regulation which we promote and stand behind, as fundamental to safeguarding community health, is under attack. Nowhere is this more evident than in the attacks upon environmental laws and regulation, intended to protect our food, drinking and recreational waters, and the air we breathe. Further, occupational health and safety is also threatened. This is a reality which is difficult for us to fathom.

Yet, show me the individual, the family, or the community that does not want their air to be pure, their water to be safe, and their food wholesome. We all want diseases controlled, pollution and waste contained, and violence reduced. Our interests in achieving the objectives of public health—preventing disease, promoting health, and protecting health—are widely shared goals in the community.

We share this vision, we represent this vision; this is the vision which invigorates us. The challenge is to capture and create opportunities to meld the interests and the visions of our communities, and those of public health. In this way we can continue to demonstrate our relevance. We must find more ways to market, explain, and promote public health and its value.

Earlier this year, an opportunity of boundless proportions was created by President Clinton when he signed the proclamation establishing a national celebration of Public Health Week, scheduled for the first full week of April each year.

Public Health Week has been celebrated throughout California and proclaimed in 40 states. Hundreds of communities have recognized this event and reaped its benefits. Each of you must know the value this celebration represents as a way to market and promote public health in a coordinated, orchestrated, and positive setting. The media love it, communities enjoy it, politicians benefit from it, and staff morale is reinvigorated.

The full value of Public Health Week has yet to be realized. And while Public Health Week is only one of many activities that should be undertaken, it is too ripe an opportunity to squander. Plan now to make your local, state, and the national celebration an ongoing success. In addition, Public Health Week presents an excellent opportunity to develop and nurture partnerships. And it is through partnerships that public health will be most successful in achieving its goals.

I say we need partnerships because we don't have the resources to be successful working in isolation, because working in partnership forces us to define our role and demonstrate our value, because partners hold us accountable for relevant deliverables, and because all of us are smarter than any of us.

Partnerships create an interface, a plane in which different disciplines and talents, ideologies, lifestyles, and cultures come together in a way that creates energy, unleashes imagination, and results in mutually beneficial change. Public health leadership must be potent agents of change. We must create burning platforms of change. We must change, create change, or be consumed by the flames. But the change which we craft must also be sustainable and beneficial to society.

Among the many partnerships available to us, I continue to be struck by the great potential represented in partnerships with the faith community. When you think about the people and communities we serve, the problems of getting our health education messages and our community outreach targeted to populations at risk, it becomes immediately evident that partnerships with the faith community provide a vehicle and a bridge by which public health can touch hard-to-reach segments of our society.

Public health and faith communities share a vast area of common interest, objective, and vision. We share concern for healthy bodies and societies, peace of mind, freedom from vermin and contamination. Here is an ally for public health. You may know that a caucus is forming within APHA to bring focus to the great potential offered by linkages between public health and faith communities.

Another important partnership is developing between the public health and disease prevention component of the health enterprise, and the disease treatment and primary care component. For more than a year now, the leadership of APHA and the American Medical Association (AMA) have been meeting to fulfill this partnership. The intent is to acknowledge our common interests in health, create a platform for change in medical education and public health education, and establish a new and extensive collaboration to improve health in this country. To this end, in March of next year, this effort—known as the medicine/public health initiative—will convene the leadership of APHA, state affiliate presidents, the AMA, the Association of State and Territorial Health Officers, the National Association of County and City Health Officials, the Association of Academic Health Centers, all medical school deans, and deans of the schools of public health, and all state health officers, as well as business community and health maintenance organizations leaders, as a critical step. These are the types of partnerships that we must develop.

Now for just a moment, I would like you to think about some of our recent health history. Two years ago we saw hope in the announcement of the Clinton administration's commitment to reform the health system, or non-system—or health enterprise, as I think of it. Quickly, the true debate centered upon reform of the health care system, more specifically, reform of health care financing. Despite our best efforts, public health, and the concerns for disease prevention, health promotion, and health protection, were hardly addressed.

In this environment and based upon our principles, the APHA Governing Council, excitedly and with great anticipation, upheld the Association's commitment to a single-payer model for a reformed system. We also supported universal access and other key public health principles critical to health reform. By the time of last year's annual meeting, the reform plan was under full attack, as Harry and Louise washed away the sands of confidence from under the plan.

We maintained our vision for an outcome which achieved financial, if not system, reform and best met the needs of public health. As we gather today, the wave of reform has curled, crashed ashore, and the tide has ebbed. What is left are the flotsam and jetsam of our ideals, our principles, and our dreams still deferred. Instead of 37 million uninsured people when this great debate began, we now have a record 41 million Americans in need of coverage. The number is growing, predominantly among women and chil-

dren and the working poor. Nationally, this group represents nearly 19% of the population under 65.

Hopes that what could not be done nationally could be achieved among the states have also been dashed on rocky shores. Florida, Massachusetts, Minnesota, and Washington provide examples where statewide reform measures have slowed, are in retreat, or have been repealed. The Oregon health plan is threatened by the uncertainty of the outcome of block grants, and their full impact. In this grim scenario, lofty expectations for cost containment—as an outcome of state initiatives and private sector innovation—are drowning in the riptide.

Is there any hope for meaningful improvement? There may be grounds for guarded optimism and hope. The new congressional majority has put health on their agenda, in the form of proposed reductions in Medicare and Medicaid spending, in the politically motivated drive to balance the budget by 2002.

Managed care is also being widely promoted as the solution. There may be important opportunities for us to develop beneficial partnerships with managed care providers. For managed care efforts to succeed financially, the services must ultimately be targeted towards disease prevention, health promotion, and health protection. When viewed in this way, managed care organizations share, and their success depends upon, success in achieving the same set of basic objectives as public health.

Certainly, managed care organizations are more concerned with the welfare of their enrollees while public health is concerned with the entire population. However, we share some common interests.

Here is another partnership which public health should pursue because we have the skills, experience, and perspective that managed care organizations generally lack. If we do not pursue partnerships with these organizations, they will ultimately develop their own capacities for disease prevention and health promotion and protection. Without us, they will reinvent public health in their own image, the result being further discontinuity and lack of coordination among community-based efforts to prevent and control disease. Their epidemiological focus will be limited to their enrolled population only, and their opportunity to contribute to health status improvements for the entire community will be lost.

Hope may also be offered in the form of block grants to the states. Increased flexibility, and state-established priorities, have been offered as reasons to support block grants. But I ask: where is the hope if block grants are not funded 100 cents on the dollar? If block grants result in the elimination of national standards for eligibility and benefits? If state maintenance of effort for Medicaid is lost? If allocations cannot be adjusted for unexpected population growth, severe economic downturn, recession or disaster? Or if equity in allocation among the states cannot be assured?

Hope could also be offered in the form of performance partnership grants, perhaps. But, again, there are concerns. How will states establish their priorities and targets? What role will local health departments play? Will states adequately recognize and support the disparate needs of big cities and metropolitan areas, contrasted to rural and suburban needs? After all, urban populations and politics are seemingly low priorities in many political circles these days. Between the federal offices and the states, who will negotiate and how will negotiations be conducted, especially in light of the drastic changes and downsizing now occurring in key federal departments?

There is a passage from *The Second Coming* by W. B. Yeats that is applicable today, as it describes our growing inability to cope. He wrote, "Turning and turning in the widening gyre, the falcon cannot hear the falconer. Things fall apart; the center cannot hold."

The evolution of resistant bacterial strains threatens to outpace development of new drugs and threatens the ability of public health professionals to protect the community. Enterococci are developing resistance to the last drugs of use against them. Concern is increasing about rising drug resistance among pneumococci, which claims more than 40 000 lives a year, not to mention the morbidity in this country alone. Resistant forms of tuberculosis are spreading, especially among the homeless and those infected with human immunodeficiency virus (HIV).

Dengue fever, and the related dengue hemorrhagic fever, viral diseases long known and feared in the developing world, now threaten the United States. Nearly 700 cases of dengue fever were reported recently in the Mexican state of Tamaulipas, 10 miles south of the Texas border city of McAllen. Three hundred cases were reported in the town of Reynosa, Mexico, directly across the border from McAllen.

Until recently, proper use of pesticides and public health programs aimed at eliminating sources of standing water had controlled this public health problem. Now, such programs have been reduced as a result of competition for public health resources. Such programs fall victim to the politics of zero-sum gain in public health.

Worldwide, increasing encroachment of communities upon forested areas, concomitant deforestation, and global warming have favored the growth and spread of disease vectors. With so many other examples to point to, our hard-won and precious disease-controlled era may now be behind us. Before us looms the threat.

The recent report by the World Health Organization reminds us that infectious and parasitic diseases are the leading causes of mortality on the planet. However, taken together, heart disease, stroke, and cancer disorders associated with longevity, tobacco use, and lifestyle choices kill more people worldwide. From a public health perspective, much of the mortality and morbidity from these causes is preventable.

Smoking and tobacco use are the world's largest preventable causes of illness and death. Accidents and violence together represent a huge source of death and disability worldwide. In the United States, violence was recently referred to as the "polio of the 1990s." Violence, specifically gunshot wounds, is the leading cause of crippling spinal cord injury among Black men, now outranking automobile injury, falls, and sports injury. Firearms now surpass motor vehicles as the leading cause of traumatic death. This fact should jar us all. It is an appalling milestone and a disgrace to our society. Children killing children no longer shocks our society.

It is not much safer in our workplaces. On average, 18 people a day are killed while on the job. The number of on-the-job fatalities increased 4% between 1993 and 1994 alone.

While some progress is being made in reducing drug use, especially among younger populations, in California we find young people more tolerant of drug use and more likely to report experimentation when compared with youth in other states. The same can be said for tobacco use. In alarming numbers, grade-school children are using inhalants as intoxicants, which is sounding an alarm throughout the substance abuse and law enforcement

community. Turning to the kitchen cabinet, garage, or desk drawer, children are using butane, correction fluid, gasoline, and even horse muscle relaxant to achieve a rush. More children report inhalant use than lifetime marijuana use.

We also see young gay males straying from safer sexual practices in an environment of great risk of exposure to HIV.

We need to rethink the problem of babies having babies. We have concluded, too casually, that teenaged births result from reckless sexual behavior of teenagers. However, more often than not, the father is a grown man, 20 years of age or older. We must address this problem in new ways targeted towards teenaged girls, young adult men, and the society surrounding them.

We have yet to find the keys, the right messages, the effective approaches.

Now, I could not have this opportunity to speak, especially in this setting, without mentioning community water fluoridation. As you know, this year we celebrate 50 years of municipal water fluoridation. From its start in Grand Rapids, Mich, fluoridation has expanded to the point where over half the population of this country now has the benefit of this important public health measure. California ranks low among the states with regard to the percentage of population using fluoridated water systems. Less than 16% of Californians have access to fluoridated water systems. However, with the passage of AB 733, California now has legislation promoting this measure in all California communities greater than 10 000 in population, based upon funding availability. While San Diego is not fluoridated, we have been working to initiate fluoridation in the city of Los Angeles. There is currently a city council motion intended to result in fluoridation of the city's water supply.

This is the type of challenge that causes a public health practitioner, a public health dentist, to salivate. This is the type of challenge that any of you, from nonfluoridated communities, must undertake.

So what do all these factors mean for the practice of public health and this great Association? Consistent with our meeting theme, we must never forget that we are the health arm of a political process. We must make decisions and recommendations with this fact always in mind. This is a challenge, especially because we know that the root causes of so many public health problems are not found in biology but in behavior and the choices we make. Root causes and solutions are also found in jobs, the economy, opportunity, and education, as well as in social and environmental justice. We know that in a more rational world, medical care would be part of public health. But it is not, and public health inherits the system's failure.

What we as society do about hypertension, tuberculosis, sexually transmitted disease, lung cancer, and oral pharyngeal cancer, hepatitis, diabetes, HIV, and other conditions must go beyond excellent medical treatment. These conditions are preventable, or are amenable to early intervention and control. These are public health challenges. Their mastery represents a great contribution to society. There is no medicine for low birthweight, no surgery for lead toxicity. As it is now, the product of our health enterprise is not health; disease treatment is the product of our health enterprise. We know these simple facts; we simply must get others to understand them as well. We must market our value.

In the tone of Harry and Louise, we need to say, "It's 11 PM, do you know where your drinking water was last night?" That question grabs attention and causes reflection. Or we might say, "Treat people like dirt." We commit resources to soil decontamination, requiring exacting clean up, for public health problems that may affect 1 person in 1 million. Yet, we often fail to provide sufficient resources for problems that affect one in ten thousand, or one in a thousand. We know that farm animals often receive better health care than humans. Consequently, perhaps we should treat people like dirt! Franklin D. Roosevelt understood this when he said, "The nation that destroys its soil destroys itself."

We know the value of our purpose and our vision. We know that the bigger the vision, the longer it takes to achieve. We need to provide leadership and vision in the political environment of the zero-sum gain. In that context, we need to ensure that resources are targeted at problems equitably.

The politics of zero-sum gain implies that public health programs and needs will be pitted against each other in desperate fights for survival. Zero-sum gain and capped block grants to the states imply that populations will be pitted against each other for a share of Medicaid support. We see in all this an abdication of federal responsibility for assuring that the health needs of the poor and the indigent are met. What little right to health care the poor and indigent had, based on upon entitlement, is being lost. That right will become a privilege which society will dole out to those considered to be the deserving poor. Consequently, along with managed care, we see what was recently described as managed abandonment.

Our task will be to drive forward, share our vision, and provide leadership which is sorely lacking and desperately needed. This is what gives the public hope. We must succeed in marketing our value and demonstrating the merit of society's investment in public health. Public Health Week, as a national celebration, provides an excellent platform to do just that.

In closing, I want to share with you a reflection on a bumper sticker popular in California during a recent period of debate on public education. The bumper sticker read, "If you believe education is expensive, try ignorance." A fitting corollary for us is "If you think health is expensive, try disease." Perhaps this can be even more simply said by the phrase "Society either supports public health, or it supports public disease."

I encourage you to use this annual meeting to rethink your vision, build new partnerships and collaborations, and return home reinvigorated and rededicated. After all, each of you is critical to transforming our public health vision into a practical and sustainable public health reality. □