Societal Change and Public Health: A Rediscovery

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An untidy row of green file boxes lines a high shelf in my office. They bulge with clippings and reprints that relate to my needs for one reason or another. They are catalogued in a way that would strike despair to the heart of any competent file clerk. Promising labels such as Policy, Poverty, Manpower, and Consumer are scratched on the boxes but their meaning has never benefited from much precise definition. Articles do not always lend themselves to specific categorizing. Often a search of several file boxes is required to locate a desired clipping—much in the way that one might search for a lost friend.

This system, chaotic as it may seem, offers many rewards—one of which is the steady parade of students who examine the green boxes, seeking help with term papers. I worry that a few papers may have been written with no more extensive search of the literature than a perusal of these green boxes.

Another reward is the brief refresher course I experience when sifting through many papers in pursuit of a lost one.

But the greatest reward of all comes from the enduring companionship and inspiration afforded by easy access to a few selected friends who are especially cherished. One file box, labeled "Public Health, General", apparently appears so unpromising to students that it seldom is searched. I know, however, that this particular box contains some of the greatest treasures of all. In preparation for this Annual Meeting of the American Public Health Association, I turned to that box and drew three items from it—each representing an individual cherished as a personal friend as well as a valued reference in public health literature.

On the shoulders of these three friends I stand today, not in a vainglorious effort to extend by status with theirs, but, hopefully, with their help to envision broader horizons than one person's vision can sweep. These three friends are pillars from which to extend our vision: Grover Powers,[1] Jessie Bierman,[2] and Paul Cornely.[3]

Grover Powers was my professor of pediatrics at Yale. His personal warmth was so great that hundreds of his students believed that each enjoyed a special relationship with him that fully justified personalization as "*my* professor".

Powers required his pediatric interns to make home visits on the family of every newborn baby who left the hospital nursery. Many of us regarded this assignment with suspicion as a temporary kind of forced exile from the reassuring comforts of professional status and technology that were provided by the teaching hospital. Other worries attached to transportation for the home visits. I was an uncertain driver, but harmonious consistency was achieved because the department provided an even more uncertain V8 Ford. As a result of that maturing experience, I am today a fearless driver. I am also respectful of the well intentioned and conscientious bungling of new mothers as they surrender their instincts and strive to follow confused professional guidance. I am further respectful of the sense of isolation of families newly transplanted from a familiar community to the anonymity of a sterily-packaged housing project. I am especially respectful of the homemade red wine so freely dispensed by exuberant second generation Italian families in New Haven. As you may suspect, some aspects of home visitings were never fully reported in the interns' log book. But enough was reported for Grover Powers to stand firm with his belief that understanding of health requires an understanding of society. He once spoke to his third year medical students in this vein:

> ". . . discover the bases upon which a better society might be builded and human welfare promoted. Medicine of the past sought to make possible a healthy body . . . ; in a confused way it now seeks a healthy mind in a healthy body . . . ; but now and in the future, it must seek integration with life—a healthy person in a healthy society."

Professor Powers believed that a better society would derive, at least in part, by improving the behavior and refining the instincts of each person in it. He lived a noble life and he knew that he exercised ennobling effects on people who associated with him. If they, in turn, ennobled others a great chain reaction would take place so that Powers could envision a society peopled by

> ". . . those of kindlier build,
> In fair compassions skilled,
> Men of deep art in life development."[4]

Powers anguished that many people lived with such crushing oppressions that for them Christ-like precepts were a mockery. He saw hope for an equitable society, but activist reform necessary to achieve it was beyond his experience and time.

Twenty years later, in 1968, when Jessie Bierman received the Martha May Eliot Award from APHA, she responded with a grace and substance that are seldom equaled on such occasions. Like Powers, she saw a future characterized by a better society, and she pondered how differently she might have bent her earlier efforts in order to achieve it. Since she found recreation in fishing she developed a refreshing metaphor around that theme, saying that if she were to revise her efforts it would be to fish in the waters a little farther upstream. In this way she could better identify the causes of increasing pollution, and exercise a preventive in-

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fluence. She had worked with greater wisdom and enlightenment than characterized her time—in positions of local, national, and international responsibility—to establish special services for "an ever increasing load of defects, deficits and disabilities of body, mind, and spirit. . ." With candid hindsight, she reflected that her efforts might have been better spent had she ventured up river to find out who was making decisions that affected the area. In that context, she would then be bold and work outside her own field of training in order to influence decision processes in favor of "better housing, less population density, better educational opportunities. . ." And she would impress her understandings of health and its determinants on businessmen and politicians in order to achieve an ecological programming for an environment in which children could thrive.

Three years later, in 1970, reinforced by reforming promise shown by domestic rebellions of the 1960s, Paul Cornely spoke of hope for a new society that was free of hidden enemies of health.[3] He saw these enemies as: (1) addiction to the abundant life; (2) perversion of democracy in favor of vested interests; (3) pollution of the minds of children with advertising that programs for behavior destructive to their well-being; and (4) racism. Cornely called for social metamorphosis brought about by populist fervor and courage. He yearned for a future in which people rather than technology became the central purpose of society, and in which the functional incorporation of minorities into democratic governance combated economic oligarchy. Cornely fished even farther upstream. He advocated political activism in the interest of health, and confrontation of agencies and corporations for a responsible accountability in behalf of the commonweal.

These three pillars—an academic patrician, an inspired and energetic bureaucrat, and a public health statesman turned social activist—provide vantage for a vision they all shared but which they found independent of each other. In each instance this vision came late in their busy and dedicated lives. That vision saw social reform as the essential avenue for improved health. Better science, better technology, better services would not be deprecated by any of the three. But these benisons achieve value only in their application and extension. The science of what benefits people vastly exceeds the science of how to make those benefits generally available. The words of these three friends ring today with confidence that the future *will* find a way, that a better society *will* be builded, and that therein good health *will* abound. It is my belief that those processes of discovery are now all around us and that we should recognize them and give them support. The American Public Health Association is one of the few institutions of our society that can play a meaningful and even decisive role of support for significant societal reform.

Before developing that theme, a digression seems appropriate to recall to you that the interrelationships of social reform and public health settle comfortably with each other and share a long history of mutually beneficial association.

Historically, the very beginning of public health and its periods of greatest advancement were associated with movements of social reform and activism. During the 100 years of organized community public health influence in this country, three periods of intense achievement stand out most prominently: Late Nineteenth Century; reforms culminating in the Social Security Act of 1935; and social unrest of the 1960s.

Laws and regulations to protect health go back thousands of years into religious and governmental history. The early years of our own young republic saw the establishment of a real but limited federal role for operation of a Public Health Service. But extensive organizational involvement of government in order to protect the public's health at the community level came during mid to late Nineteenth Century. That period saw the establishment and organization of health departments, empowered with the full regulatory and enforcement functions of state and local governments.

The genesis of health departments was more a matter of desperation than of enlightenment. Industrialization had spawned cities that were crowded, filthy, and disease-ridden. Fearsome epidemics swept through urban populations, threatening rich and poor alike. Activism by the poor produced the tangible results that history recorded. Duffy's history of the New York City Health Department[5] documents that the New York City riots of 1863 evoked constructive action in a way that Lemuel Shattuck's scholarly report had not. Shattuck had developed a plan for an integrated health program 13 years previously. Despite conscientious efforts by community reformers to enact his plan in Boston and New York City, little was done until public demonstration demanded it. The 1863 draft riots were essentially a revolt of the poor against privilege and property. From that uprising, community public health in this country had its beginning. This significant phase of achievement organized the power of local government around improved sanitation and epidemic control.

Public health's next phase of significant achievement took place during the first one-third of the Twentieth Century, and its watershed was enactment of the Social Security Act of 1935. A new set of problems, largely of a social rather than an environmental nature, was now confronted. The focus for their resolution shifted from the power of *local* government to the authorizations and fundings of *federal* government.

This era of Twentieth Century America witnessed a reformist zeal that today seems awesome, and much of its energy and inspiration came from new careerists: women social workers. Their targets were such issues as child labor, women's voting rights, security for the elderly, and alcoholism. Reformists hit a bullseye with every effort *except* prohibition, and most thoughtful observers today are eager to take another look at ways in which responsible government can address the pervasive health hazards of intemperate alcohol consumption in our society. This same period witnessed major reforms in medical education, establishment of the Children's Bureau, public funding of maternal and child health services, and a temporarily sympathetic posture toward compulsory health insurance.

Those who sought in the 1930s to build a better society in America by advancing federal responsibility for health compromised some of their objectives out of fear of a conservative Supreme Court. But a federal role *was* established

to provide resources for health services: facilities, manpower, technology, and purchasing power for consumers. Under Title V of the Social Security Act a federal role to finance and monitor* the work of state and local health departments was established—at least with respect to maternal and child health services. And a clear mandate was assigned to the federal government to participate directly with consumers and community groups in organizing and operating demonstration health service projects.

Burns has analyzed a paradox established by the Social Security Act.[6] For some titles—such as payment of pensions—the federal government is placed in direct service to consumers, bypassing state and local governments. Other titles (Maternal and Child Health Services under Title V) require the federal government to work through state and local governments.** Subsequent amendments to the Act did not clarify this paradox.

While the direct route from federal government to consumer was taken for Title XVIII, the state route was established for Title XIX. Much of the controversy over National Health Insurance centers around which of these precedents will be followed. That paradox is not the subject of this report, except as it illustrates the important but uneven accomplishments of social reform to advance the cause of public responsibility for health. Social commentaries on the 1930s confirm that powerful forces for social change were at work. A precedent for those who marched on Washington in the 1960s had been set by the veterans who marched against their capital 30 years before.

Powerful reformist forces were again at work in yet another phase of significant advancement in public health during the 1960s which saw the enactment of a flurry of health legislation. That flurry has not yet been well conceptualized into a cohesive and firmly established new watershed of public policy. The reformist forces are still at work; they began after World War II with efforts to extend public responsibility for programs on behalf of handicapped children; but they find most conspicuous expression in the Civil Rights movement and the subsequent Black Power and Chicano movements, in the youth rebellion, and the Women's movement. These are efforts on behalf of human rights. Although each of these efforts has characteristic causes of its own, and articulate advocates on its own behalf, each of them also, whether willingly or not, works on behalf of public health. The extent to which each of these endeavors meets its own objectives may depend very much on the extent to which they can find common cause with the others and with economically repressed people of all ages, sex, and ethnic origins. The cause of public health represents one of the most urgent and promising arenas in which they can work together. This collaboration, for the most part, is fostered neither by their design nor by ours—but because we all share an important issue. That issue is human rights. It is the central theme of current efforts toward societal change.

As advocates of public health, we advocate rights to health services and to the social supports and safeguards that allow people to enjoy dignity, fulfillment, and well-being. Those same rights are fervently sought as part of the agenda for each of the reformist movements. We share a common cause. The unique contribution of public health toward its fulfillment may be to establish accountability of public agencies that can secure and protect those rights.

Fuchs contributes much to our understanding about health and human rights.[7] He draws this comparison with education. Laws affirm the right of every child to education, but not to wisdom. The latter embraces complicated considerations, including an individual's emphasis of endeavor. Laws may, in time, affirm an individual's right to health services and social supports, but they cannot guarantee health. That, too, embraces many considerations—including an individual's choice of behavior and life style. But the point may be too finely drawn. For the vast majority of people in our society the life circumstances leading to poor health are not adopted as a matter of personal choice, but are thrust upon people by the social and economic circumstances into which they are born.

Court action is moving slowly but certainly to establish rights to health services. The recent action in Alabama requiring that active treatment accompany forcible institutionalization is one step. The action concerning St. Elizabeth's hospital which stipulated that community health services be provided for patients discharged from the hospital is another step. The action in New Hampshire that qualified an unborn baby for aid to dependent children is also an important step. Several test cases that imply negligence on the part of local authorities who have failed to enforce housing codes that protect from lead poisoning may be another step. And the 1973 Supreme Court ruling on abortion was an important step.

Other potential avenues lie open. The time honored concept that health professionals hold the public's health in sacred trust is giving way before the belief that conflicts of interest may pertain to health agencies and institutions as well as to other enterprises. Why should consumer groups fight for a place on local and state boards of health, or planning bodies, governing boards of hospitals, and non-profit insurance companies, or on commissions of licensure and accreditation? Would not those efforts be advanced by challenging the propriety of anyone—be it physician, banker, or manufacturer—to hold such a post if that person at the same time holds a financial interest in the work of the authority being served? And why not search for test cases that might affirm local government's responsibility as fiduciary on behalf of the health of its citizens? Many laws suggest that role, even if public performance seldom fulfills it. The newly established health law unit within APHA should make exploration of these and other opportunities a feasible prospect.

All of these endeavors offer high promise for constructive collaboration between APHA and reformist groups with

*Monitoring functions are in a doubtful state. The Act required every state to submit a plan acceptable to federal government before formula funds were granted to the state. The plans were never required to meet rigorous standards, and rumors circulate that since 1971 no one in DHEW has been permitted to read the plans, although they continue to be filed as required by law.

**Through a later amendment to Title V, federal government worked directly with consumer groups for purposes of demonstration: Maternal and Infant Care and Children and Youth projects.

mutual concern over issues of health and the rights of humankind. The success of these endeavors calls for consideration of the critical economic constraints placed on public health.

Most policy analysts agree that, although these times are especially stressful for public health emphasis, our national health policy has always favored private market systems for the preservation of health, to the point of fostering false expectations of what Adam Smith's "unseen hand" can achieve on behalf of preventive health services. The Hill-Burton Act for the construction and refurbishing of hospitals, medical technology supported through the National Institutes of Health, manpower training grants, and Medicare payments on behalf of services for the elderly can all hang together under a coherent national health policy only if they are construed as a patchwork of subsidies protecting a faltering system of private medical care. In recent years, PSROs, HMOs, and most of the currently fashionable proposals for compulsory national health insurance joined with earlier efforts to provide more resources and whatever minimal regulation may be necessary to keep private medical care solvent and accountable for substantial public funding. Efforts to introduce health maintenance into Health Maintenance Organizations have failed, and current efforts to urge that National Health Insurance guarantee the delivery of health services to people—rather than the delivery of more money to hospitals and doctors—may very well fail also. The United States House of Representatives Ways and Means Committee has shown interest in the American Public Health Association's proposal for a national health insurance program that would cover first dollar costs for preventive health services, and guarantee the availability of those services as a health benefit package for every age group. But it is too early to feel confident that this emphasis will prevail. The Department of Health, Education, and Welfare gives some notable encouragement, but little commitment in the revised version of the *Forward Plan*.[8]

The private market system, equalizing supply and demand around a negotiated price, carries potent credentials as a device for distributing goods and services in the western world. This system is sufficiently secure in that its defenders need not feel threatened by criticisms that the private market is not a suitable device for all people in a society, nor for every service those citizens require. Many national leaders, with impressive credentials for support of our capitalist system, have worked on behalf of some services in the public domain. But, in today's economic climate, Andrew Carnegie might very well fail in his effort to establish a free public library in every small town, since it surely would be construed as an unfair encroachment on the trade of bookstores.

We live today in the midst of a national mania that glorifies private market systems and profit motives. Public service programs are vilified, and we turn away from evidence suggesting corruption or venal characteristics of our nation's health service market that work against the public interest. Political opportunism has led many leaders to charge that we spend too much on welfare programs, no matter that we spend less of our Gross National Product for such purposes than any industrialized nation of the world. When reports circulate that the Social Security Administration has overpaid Medicare providers by many millions of dollars, we think at once of the inadequacies of the federal bureaucracy and the bumbling of monolithic government. We do not think first, as we might, of the abuse of public trust by private intermediaries. A case can be made that bureaucracy does work very efficiently indeed for a number of health services. The greatest bumbling may occur, however, when the private market system is interposed between agencies of government and the intended recipients of their services. Scandals about nursing homes, profit-seeking HMOs, and the soaring administrative costs of the private health insurance industry all serve as cautions about an approach to public responsibility for health which attempts fulfillment only by paying the bills in a free market system.

Fuchs has emphasized that our understanding of health economics is limited and that considerable evidence suggests health services do not conform to widely accepted economic principles. Supply does, in fact, create its own demand, in relation to hospital beds, as Roemer pointed out in 1959,[9] and in relation to physician services, as Ginzberg suggested in 1969.[10] Navarro has recently documented that increasing the supply of physicians does not improve their distribution; they continue to concentrate in the Northeast regions and especially in suburban areas.[11] Additionally, an increased concentration of physicians does not result in the kind of competition that improves the product and lowers the price. The growing concentration of surgeons in suburban areas has resulted instead in a shortening of their work week to an average, in some areas, of only 34 hours per week, while still maintaining their incomes at previous high levels averaging $60,000 per year. What has this meant for the public's health? It has meant that 4 to 10 times more tonsillectomies are done as can possibly be justified, as well as a shocking increase in cesarean sections and discretionary surgical procedures.

Many leading analysts feel that improved health services will need to rely on the extensive use of innovations in health services, such as the utilization of nurse practitioners and other non-physician providers. This may be a faint hope, if the nation continues to rely on private market systems of care rather than on public service agencies. Our market system is conspicuous for its failure to incorporate some of the most important innovations of health services of this decade—such as consumer participation, use of indigenous health aides, use of nurse practitioners, incorporation of environmental and legal concerns into the context of health services, and outreach programs to high-risk populations. In fact, the most promising innovations for improvement of health have derived from publicly-supported and sponsored programs of care established on a non-profit basis. These are the programs which have made extensive use of nurse practitioners and outreach efforts to high-risk groups: maternal and infant care projects, children and youth projects, comprehensive neighborhood health centers, and many of the most progressive local health departments. We know a great deal about ways to improve and extend services to hard-to-reach population groups. We have failed completely to institutionalize these innovations into our prevailing systems of health service.

Not only has the market system failed to incorporate innovations, it has also failed to make acceptable widespread use of the established wisdom on which improved health has been based for many decades. We continue to live with circumstances in which as few as one-half of our school children have been completely immunized against such diseases as poliomyelitis, measles, or diphtheria, and where as many as one-third of the pregnant women in inner cities report in labor to emergency rooms without having any prior prenatal care.

One of the most forceful and concise statements of national health policy was published by the Nixon Administration in January of 1973 as an overview for the proposed federal budget for FY 1974. That policy declared that the federal government is "inappropriately" involved in the direct offering of health services, that market systems are the only American way for supporting and rendering such services, and that, insofar as there may be a public responsibility for health, it should be decentralized to the states and supported in part by means of revenue sharing.[12] Although scandals in government forced a change in the Administration's leaders, their health policies have endured—never again so openly stated, but nevertheless forcibly duplicated in succeeding proposed annual budgets and in repeated reorganization of the Department of Health, Education, and Welfare.

Categorical programs, for which the federal government assumes a direct responsibility for circumscribed services on behalf of defined consumer groups, are regarded by prevailing policies as especially offensive. Nutrition programs, maternal and child health, neighborhood health centers, training of public health workers, family planning, and many others have been earmarked repeatedly for elimination or for substantial reductions of funding. The influence of public health leaders on these policies has been, through diligent hard work, to achieve, at best, some lesser defeat than the Administration proposed.

Faced in 1973 with the prospect that many categorical public health programs would lose their separate identities and be lumped into aggregate funding, many public health advocates who had never been very enthusiastic about categorical programs in the first place—preferring in theory a comprehensive approach to health services—fought to save the separate categories, fearing that placement of all those eggs in one basket (called 314d) would endanger vital programs if the whole basket were dropped at some later date. The Administration's proposed budget for 1976 confirmed those fears and dropped that basket. Fortunately, it was retrieved at the last minute by congressional override of the President's veto.

If we live, as has been suggested, among powerful forces for social reform, then how can current retrogressive policies persist? The answer to this was extensively exposed in a recent series of articles in *The New Yorker* by Jonathan Schell which analyzed the strategies of the Nixon Administration.[13] The full and awful effects of those frightful years have not even yet been fully realized; their influence endures. Mr. Nixon's policies were made to prevail by means of his practicing a politics of divisiveness: pitting youth against the establishment, white against black, women against the family, workers against welfare recipients. Any and all reforming causes were pitted against each other in an effort to neutralize their impact on significant societal change. Every constructive liberal effort was made to appear ridiculous or fanatic, and every potentially effective source of criticism was blunted by contrivance that required it to defend itself from attack from a potential ally. If youth seemed not provocative enough, youthful hecklers were programmed and planted in televised public gatherings in order that all young people could be ridiculed. We live still with a politic of divisiveness. New York can sink in its own end of the lifeboat.

If it now seems that much of the steam has gone out of the civil rights movement, the youth rebellion, and the women's movement, it is not because they have won their causes, but rather because they are momentarily confused and weary. It is time to regroup. These endeavors have carried the major burden of responsibility for societal reform which other people have sought in more cautious ways. Powers, Bierman, and Cornely—and many of us in APHA—seek to build a better society. Those among us who are in the vanguard for change deserve our encouragement, our support, our expertise, our resources, and—perhaps most important of all—a climate in which they can seek and find endeavors which can be shared with each other. Public health is such an endeavor, and the American Public Health Association provides such a climate.

There are some specific endeavors around which I believe APHA could establish a new watershed in public health. Foremost among them is the firm establishment of local government's responsibility for health as maintained by both personal and community health services—reaching those people and providing those services neglected by traditional delivery systems. On this base, state and federal government stand as the residual guarantors of services, equalizing the inequities of local discretion.

APHA could undertake new initiatives to advance these causes. Consideration should be given to the following:

1. APHA should become more vigorous in providing direct help and support to local health departments. Local government and its health departments may at times be vulnerable to local influence by self-serving interests. Outside reinforcement for the health department may be helpful at these times. A large panel of experts designated by APHA could provide consultative and supportive services on matters pertaining to health law, occupational health planning, environmental protection, personal health services, as well as on the monitoring and evaluation of these functions. The influence and prestige of a vigorous national organization such as ours could help bear some of the burdens which local health departments may be too vulnerable to endure alone.
2. APHA should initiate a coalition of reformist groups to begin systematic challenges to self-serving interests that weaken local public service agencies. Assistance of the courts should be invoked, as necessary, to eliminate conflicts of interest. Industrial polluters who control environmental protection *must* be challenged, and private medical providers who maintain

their presumed prerogatives by keeping health departments weak *must* be confronted. When regionalization of health jurisdictions offers promise for improved services, small and parochial political units must be challenged to meet that promise either by improving their services or by merging them. This sensitive work cannot be undertaken only by local reformers unaided by outside influence.

3. On the national level, APHA should mount a campaign to force commitment of a substantial portion of shared revenues for purposes designed to improve health. Many organizations would join that effort. Such a federal commitment would forestall action like that taken recently by the Arizona legislature which committed the entire current year's shared revenue as a tax rebate to property owners.

   In order to safe-guard against a fixation that local government may hold for using shared revenues only for capital improvement, specific provision should be made that these funds will recur in order to support operating costs when federal health standards and goals are accepted. Under special circumstances, pass-through funding from federal shared revenues to local health departments should be provided. Such pass-through funding should be considered to prevent epidemics, to maintain acceptable standards of preventive health services, and to support human rights.
4. APHA should investigate advantages that might accrue from health impact studies. Public Health Departments might become active participants in such health impact studies. Any project spending federal funds would be required to file a study of the impact such programs would exercise over the health of people. Environmental impact studies now may or may not include specific provisions for emphasis on human health. A national commission of experts from APHA could work to assist local jurisdictions to undertake and execute such studies.
5. APHA should attach renewed emphasis to the enactment of National Health Insurance only as a reform measure. Attention already has been given the priority of prevention. Efforts should be renewed to expand public services under national health insurance. It could provide special funding either through capitation or a percentage payment of the total insurance budget in order to support community public health and supportive social services. Without the inclusion of community and social support services—such as outreach, home health care, family counseling, substitute mothers, preparation for parenthood, instruction in mother-craft, recreation, school health, social casework, and day care—and without some provision to establish health service programs for populations who are bypassed by conventional private modes of care, the payment of physicians and hospital bills under national health insurance would be an extravagant mockery.
6. I have saved to the end, in order to emphasize its importance, the theme of this entire meeting—Work and Health in America. Here, indeed, is an arena for the most intensive kind of effort on the part of APHA and all of those who would join it in building a better, more healthful society. Specific recommendations should come out of this meeting; the closing session is designed for that purpose.

In drawing to a close, allow me to express profound gratitude for the privilege of serving you and this Association as president. I cherish new friends, new colleagues, and new causes that I have embraced in an effort to reach out in fulfillment of responsibilities that have been both demanding and exhilarating.

I especially wish to express appreciation to and continuing confidence in Dr. William McBeath and the staff of the Washington office of APHA. They are among our greatest assets.

Against the background of a year's intensive effort on behalf of the Association, I presume to give a word of advice on the Association itself. We can take pride that during a time when other professional associations are losing membership, influence, and support this Association is gaining in all these respects. We are stronger, more influential, and more financially responsible than at any time in recent years. Some alternatives of organization, structure, staffing, and dues payment may still persist. But, we must bear in mind that we are not building a fine Swiss watch. Organizational perfection is not my interest and I hope not yours. Every time we undergo major changes of organization we produce uncertainty, discontent, and alienation of part of our membership. We are committed to causes; let us continue with them. We should not expect that organizational perfection will somehow magically put into effect the creative ideas, imaginative concepts, and strong commitments in public affairs and science that characterize APHA. The perfect organization will not accomplish these goals for us. We need to work harder to take full advantage of the strengths and ferment of the climate of reform in which we live. A new watershed for the people's health is before us. APHA is in the best position of any time in this century to build that watershed in the public's interest. It will be built on the companion endeavors of firmly established rights to health services; and on firmly established accountability of public agencies to protect those rights.

Finally, our very concern for societal change emphasizes again our basic and long term responsibility for continuing development of the science and technology of health. Let no one presume that emphasis on societal change deemphasizes responsibilities for continuing scientific achievement. On the shoulders of the scientists among us fall the greatest responsibility of all. They must continue to provide the wisdom around which standards and goals for health services can be established. The vigorous reforms of public health during late Nineteenth Century were made possible because scientific advances provided the base on which sanitation and environmental controls could be enforced. When the crisis of the depression came, a sound Social Security Act could be written because its framers had done their homework over three decades in order to sort out sound pub-

lic policy in the uncertain new field of social science. And the societal unrest of today—based so heavily on concepts of individual rights to services—desperately needs the firm foundation that scientifically established standard setting can lend to answer the challenging question of: rights to which services.

APHA's great strength is its diversity—we legitimately represent many different causes. Central to them all is concern for the well-being of people, and therein lies the key which makes our diversity a strength and not a weakness. It could be the latter; the diversity of our nation was used for divisiveness and we still cry to be drawn together. Organizations such as ours can show the way; the force that unites us is a concern for each other. We achieve our purposes, not by working against causes within APHA that are different from our own, nor by achieving domination over them, but by understanding them. The courage of our convictions is not sufficient—we fortify ourselves with the courage of convictions which we share. Edith Hamilton described it better than anyone else as:

> ". . . a great stage on the long road that leads up from savagery . . . toward a world still so very dim and far away that its outline can hardly be seen; a world in which no individual shall be sacrificed for an end, but in which each will be willing to sacrifice himself for the end of working for the good of others in the spirit of love with the God who is love."[14]

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