EDITORIALS

Time to Embrace Public Health Approaches to National and Global Challenges

Many challenges face us today at the local, national, and global levels in assuring the health and security of all individuals. The population-based prevention focus of public health, which is the practice of social justice, offers an approach and potential solutions to major national and global challenges, such as universal health coverage, military investments, climate change, and women's and children's health. As Martin Luther King Jr stated in 1963, "An injustice anywhere is a threat to justice everywhere." Today there is much to do at the local to global levels to address these injustices in health and well-being. At this critical time in our country's history, with a forthcoming change in administrations, the challenge for the public health community is to articulate how public health works and to develop the political will to invest in this approach.

UNIVERSAL HEALTH CARE

First and foremost, a public health approach is needed to address the crisis in our health care system. The growing number of the uninsured in this country is estimated to be 47 million people (for 2005)[1]; at the same time, the cost of health care as a percentage of the gross national product continues to rise. Even if various cost-saving strategies, such as reductions in administrative costs and insurance company profits, competitive drug pricing, and chronic disease care management, were implemented, these savings would be within the "medical care box," accounting for only 10% of health outcomes for the population.[2] The biggest savings can only come from prevention of chronic and communicable diseases in the first place, so that fewer individuals end up with health conditions that drive up the costs of medical care. This implies that major investment is needed in the public health system to address behavior and lifestyle changes, as well as environmental conditions that are necessary for population health improvements. The creation of a universal health care financing and coverage system, although a critical step and condition for better health, is necessary, but not sufficient, to improve the health of the public.

A public health infrastructure that embraces a population-based, systems development approach using the core three functions and ten essential services of public health is needed at the local, state, and federal level to prevent disease, promote health, and protect all residents.[3] The public health approach uses a socioecological and social-determinants framework that assures key determinants of poor health—poverty, racism, unemployment, and a variety of conditions associated with unacceptable health disparities—are addressed. As our successes in combating tobacco use have shown, a multisector, multicomponent approach to supporting individual behavior change is critical. A key component of this strategy must include publicly funded marketing and the use of media to provide evidence-based information to the public to support individual- and population-level behavior change.

Three key messages should be included in the national and state debates occurring today concerning health care reform. First, health care is a public good that is necessary for a thriving economy and global development. Second, federal reforms that support a universal single-payer system and provide health services to all, as we currently do for those 65 years and older through Medicare, are critical and necessary to achieve universal health care for all Americans. Third, a fully funded public health infrastructure is needed at the local, state, and federal levels, because only this investment in public health can prevent disease and improve health for the population in the future. Public health practitioners and researchers must advocate forcefully for the inclusion of public health in state and federal health reform!

MILITARY EXPENDITURES AND FOREIGN POLICY

The second issue that cries out for a public health approach is the nation's military and foreign policy. First and foremost, we need to stop the war in Iraq as a first step in redefining American foreign and military policy, to be followed by a thorough reexamination of military priorities, which have not been seriously reevaluated since the end of the cold war almost 19 years ago. We need to stop major investments in weapons systems that are neither effective nor needed for our country's defense, and adhere to all global treaties on the containment and

elimination of chemical and nuclear weapons, biological pathogens, and related systems.

A major reinvestment of much of the current $700 billion military budget (which is about 70% of all discretionary spending)[4] should be made in priorities that address the social determinants of health necessary for our "common security." These priorities include adequate housing, welfare, social services, education, transportation, bridges and roads, updated water systems, a public health infrastructure, and a variety of key community programs, many of which have been excluded from the presidential and congressional budgets in the past eight years. As is true with health care reform, public health offers solutions to conflicts and terrorism by building healthy communities; it also has the tools to alleviate the suffering and impacts of conflicts during the conflict and afterward.[5] At a minimum, we must fight for the full range of mental health and other much-needed supports for all veterans returning home from the battlefield.

A woman pours tea boiled in a solar oven in the Iridimi refugee camp that was manufactured on-site by the Chad Sun company. Besides being emission free, the solar oven saves women from the risky and daunting task of gathering firewood. Printed with permission of Corbis.

CLIMATE CHANGE

Another current challenge is the inevitability of global warming and climate change on human health and well-being. Recent articles and discussions have led to a tipping point, whereby most acknowledge that global warming is occurring. Examples of the impact are the disastrous hurricanes on the Gulf Coast (Katrina and Rita), the recent fires in California, and the growing concerns about adequate water supplies (including, most recently, in the state of Georgia). Global warming will have many impacts requiring public health solutions, including increased heat, severe weather, air pollution, allergies, vector-borne and water-borne diseases, as well as decreases in water and food supplies, challenges related to the resettlements of "environmental refugees," and the resultant mental health issues associated with the stress from all of these conditions.[6] Once again, however, public health has the tools to monitor the impact of climate change and provide solutions to mitigate the impact on human health.

WOMEN'S AND CHILDREN'S HEALTH

Finally, another challenge is the deteriorating situation for women and children in the United States and globally. A necessary condition for women to thrive and be healthy is to possess the right to control one's own reproductive choices and options. An investment in women's education and health leads to healthy children and healthy communities. We must assure that women have access to essential services for their health and well-being. The continued struggle for public health evidence-based strategies and reproductive rights must be a high priority for local to global action.

Our children are obviously not doing as well as they should be, especially in light of the United States' enormous wealth and economic power in the world. The US infant mortality rate continues to be at the bottom of all industrialized and developed countries (ranked 28th in 2003).[7] Increasingly large numbers of children are born into and live in households in poverty. Chronic conditions of childhood, such as obesity, asthma, and a variety of mental health and developmental conditions, are increasing at alarming rates. Large numbers of children do not have access to the early childhood health and education programs shown to improve health and productivity across the lifespan. Although there is much evidence that shows what is needed to improve the health and development of children and youth,[8] we have failed to use this knowledge. We need a transformation of the current health and development system to one that coordinates all investments for children and their families from all sectors (e.g., health, education, social services). This change is needed in every community, with a strong point of accountability for all children and youth at the local, state, and federal levels to ensure all children reach their optimal health and capabilities.[9] These assurances for both women and children are necessary, not only because it is the right thing to do, but also to maintain the US leadership role in the global economy. Public health

again has the solutions, both for prevention and health promotion of optimal health and development for women and children.

POLITICAL WILL NEEDED FOR CHANGE

In summary, current national and global challenges in a number of areas could benefit from public health approaches and solutions. The implementation of effective policies requires a public health knowledge base, as well as social strategies and political will.[10] To achieve the major public health investments needed to address the current challenges requires a public health movement committed to the development of political will for change. It also requires public health approaches to the problems of health care, climate change, military and foreign policy, women's and children's health, as well as other related challenges. This movement needs the unity of all who work in public health, as well as many partners from academia, business, community-based organizations, unions, and others, including the general public. The forthcoming US presidential election offers us an opportunity for a new direction and approach to major inequities facing our country and our world. This is a critical time to articulate the importance of a public health approach and solutions. If we in public health do not do it, no one else will! ■

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References

1. Davis K. Uninsured in America: problems and possible solutions. *BMJ.* 2007;334:346– 348.
2. McGinnis JM, Foege WH. Actual causes of death in the United States. *JAMA.* 1993;270:2207–2212.
3. Institute of Medicine. *The Future of Public Health in the 21st Century.* Washington, DC: National Academies Press; 2003.
4. US House of Representatives, Committee on the Budget. *Summary and Analysis of the President's Fiscal Year 2009 Budget.* Washington, DC: US Congress; 2008.
5. Levy BS, Sidel VW. *War and Public Health.* 2nd ed. New York, NY: Oxford University Press; 2008.
6. Frumkin H, Hess J, Luber G, Malilay J, McGeehin M. Climate change: the public health response. *Am J Public Health.* 2008;98:435–445.
7. Maternal and Child Health Bureau, Health Resources and Services Administration. *Child Health USA 2006.* Rockville, MD: US Dept of Health and Human Services; 2006.
8. Center on the Developing Child. *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior and Health for Vulnerable Children.* Cambridge, MA: Harvard University; 2007. Available at: http://www.developingchild.harvard.edu. Accessed February 28, 2008.
9. Halfon N, DuPlessis H, Inkelas M. Transforming the US child health system. *Health Aff.* 2007;26:315–330.
10. Richmond JB, Kotelchuck M. The effect of the political process on the delivery of health services. In: McGuire CH, Foley R, Gorr A, Richards RW, eds. *Handbook of Health Professions Education.* San Francisco, CA: Jossey-Bass; 1983.

Engaging Culturally Competent, Community-Based Programs in Reducing Tobacco-Related Health Disparities

Models of community-based health promotion and prevention programs are increasingly prominent as they seek to ensure active community participation and increase local capacity for engaging in prevention activities.[1] US government health agencies, including the Centers for Disease Control and Prevention, recommend a focus on community-based prevention and control strategies, as exemplified by the Task Force on Community Preventive Services.[2] Key elements of these models include engaging community coalitions in achieving program goals, implementing interventions beyond the borders of health care settings, and ensuring culturally competent approaches, such as the use of lay health advisors.

Although these models have generated funding from both public and private sources, evidence suggests that health promotion programs involving coalitions may have had limited impact on community health status.[1] That is, despite the conceptual strengths of community-based programs and a clear rationale for their continued support, evaluators have noted only modest individual-level results and limited population-level changes in health status outcomes.[1] Nevertheless, community-based interventions have the potential to reach large numbers of people, enhance cultural competency in service delivery, and promote policies to improve public health and health care.[3,4]

Attempts to trace the value of community-based programs on population-level health behaviors and outcomes may be abetted by systems science approaches.[5] The challenge of demonstrating the contribution of these programs may require refocusing the analysis on evaluating community-level outcomes and examining their role in a larger scheme of health care access and quality.

A COMMUNITY-CENTERED APPROACH

The American Legacy Foundation (Legacy) made a substantial investment in capacity building for culturally competent, community-based tobacco control programs through its Priority Populations Initiative (PPI).[6] A conceptual framework was developed to describe the collective contributions of 82 community-based PPI grantees through coalitions and partnerships toward reducing tobacco-related health disparities and fostering health-promoting change in local neighborhoods (Figure 1). Legacy

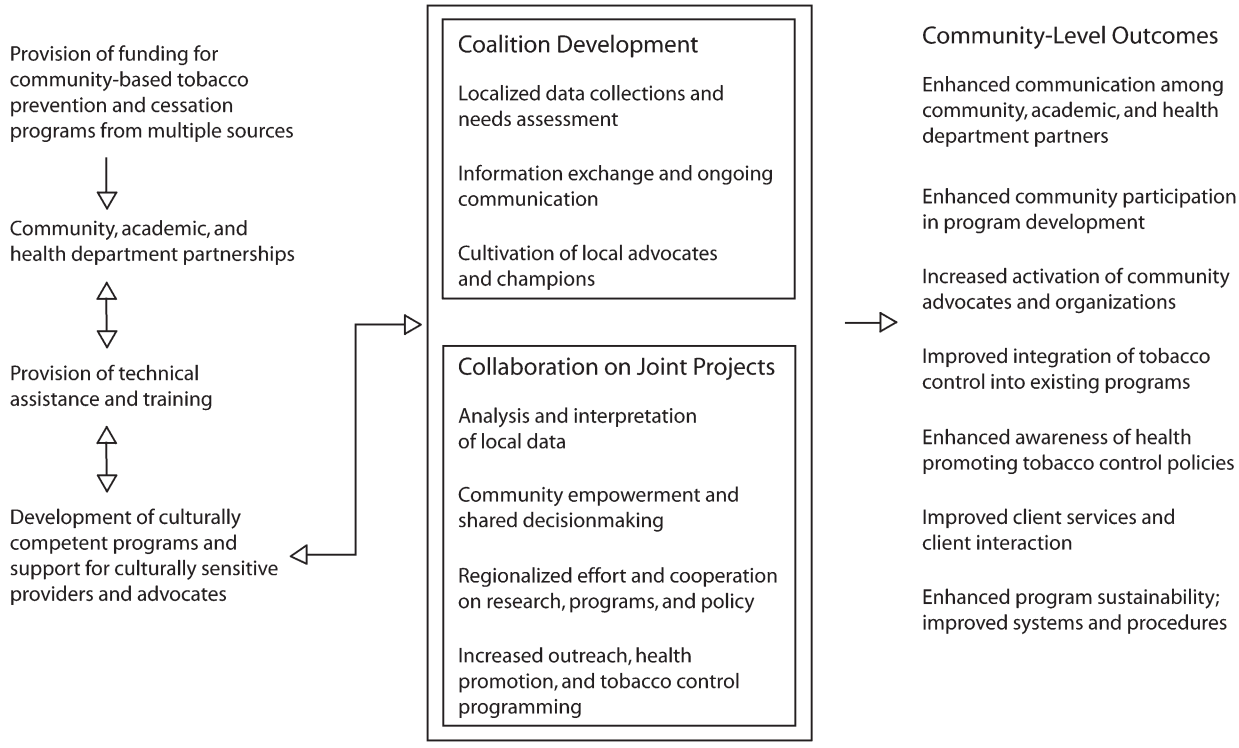


FIGURE 1—Capacity building for culturally competent community-based tobacco control.

identified and made a commitment to 6 underserved priority populations (African Americans; Asian Americans/Pacific Islanders; Hispanics; American Indian/Alaska Natives; lesbian, gay, bisexual, transgender individuals; and those of low socioeconomic status) to help people in these communities reduce tobacco use and educate their youths about the health risks associated with smoking.[6]

The chief contribution of the initiative to date has been to build capacity for grassroots organizations to create culturally tailored tobacco prevention and cessation services.[6] The benefits to these organizations and local communities have been found to be lasting and reciprocal, as depicted in Figure 1. In essence, the provision of resources helped establish culturally competent programs, which led to the participation of these organizations in local coalitions and collaboration with network partners and resulted in broad-based, community-level outcomes. These outcomes included, for example, improved integration of tobacco control activities into existing programs, advocacy of voluntary tobacco control policies, and improved program sustainability.

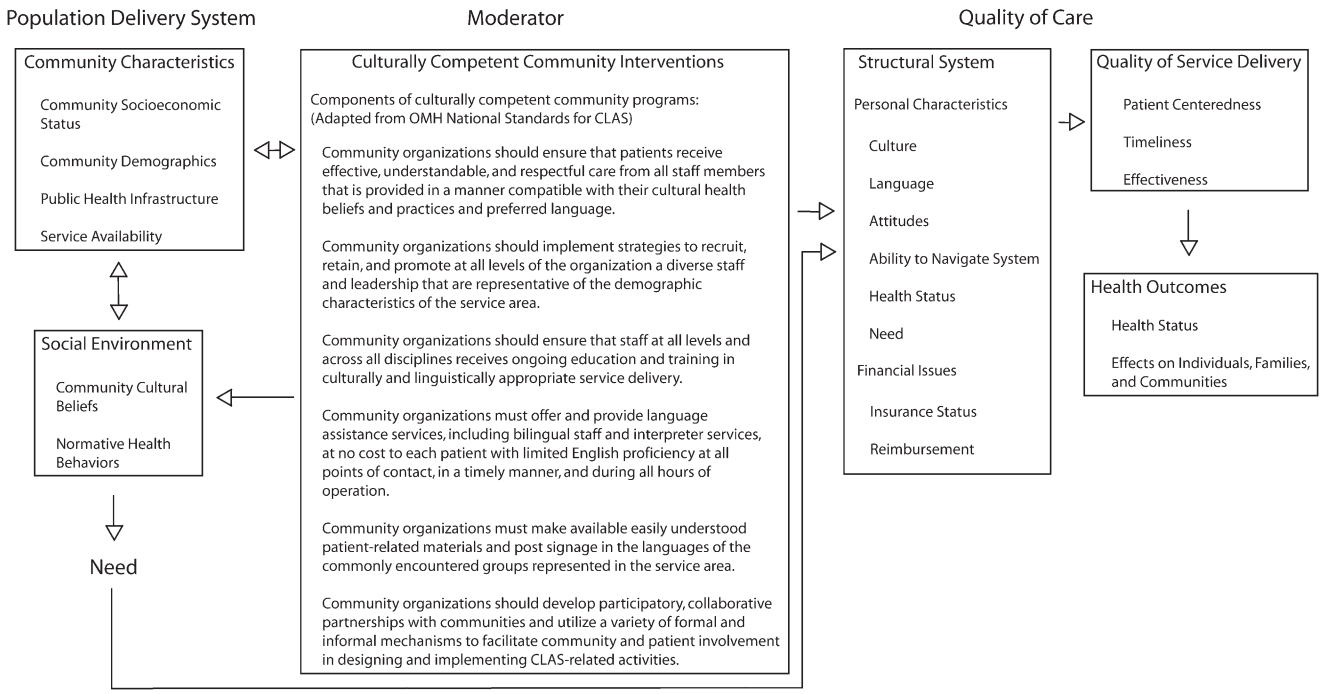
Funded projects were tasked with developing programs to effectively combat the marketing tactics of the tobacco industry, raise community awareness of the health effects of smoking, and offer creative solutions to populations suffering from the disease burdens caused by tobacco use. By funding organizations that work in underserved communities throughout the United States, Legacy extended tobacco control efforts beyond health agencies that traditionally work in the tobacco control field and helped community-based organizations integrate activities to reduce tobacco-related health disparities into their existing programs.

Through providing grants to grassroots organizations, Legacy enhanced its ability to develop local solutions to counter tobacco use. Nearly 34% of the documented activities of PPI grantees involved capacity building. Of the documented activities of PPI grantees, 34% involved capacity building and 66% involved programmatic services. For example, PPI sites were actively engaged in offering cessation services (30%), conducting tobacco prevention education (21%), and providing guidance on reducing secondhand smoke exposure (15%). Many PPI grantees thus received their first opportunities to implement grant-supported tobacco control efforts tailored for their specific populations.

The Office of Minority Health (OMH) of the US Department of Health and Human Services defines cultural tailoring as

> the extent to which ethnic/cultural characteristics, experiences, norms, values, behavior patterns, and beliefs of a target population as well as relevant historical, environmental, and social forces are incorporated into the design, delivery, and evaluation of targeted health promotion materials and programs.[6]

Accordingly, PPI grantees provided community-centered, culturally tailored services while also sharing lessons learned with one another and disseminating newly developed educational materials, both to their communities and more broadly. Cultural tailoring improved the effectiveness of PPI programs in developing messages specific to the grantees' communities regarding the harms of tobacco



Note. OMH = Office of Minority Health; CLAS = culturally and linguistically appropriate services.
Source. See references 10 and 11 for further discussion.

FIGURE 2—Role of cultural competency in population delivery system.

use. The cultural sensitivity of program staff, service providers, and health advocates played a valuable role in improving health care access and quality for the diverse populations reached by the initiative.

GUIDANCE ON CULTURALLY COMPETENT SERVICE DELIVERY

As a tool for the cross-site evaluation, a logic model was developed that included the development of culturally appropriate materials as an intermediate output. Through case studies and telephone interviews, evaluators examined the processes that grantees utilized to culturally adapt their materials and program interventions to their target populations. Evaluators also provided technical assistance to the PPI grantees on crafting objectives, as well as resource information on best practices for reducing tobacco use.[8–10] In the course of the evaluation, key approaches were empirically derived from PPI that were congruent with the national standards for culturally and linguistically appropriate services (CLAS) in health care,[7] as detailed subsequently here.

Specifically, the OMH has established 14 cultural competency standards that federally funded health care organizations are required to meet. According to the OMH, the CLAS standards have two major purposes, namely

> (1) to provide a common understanding and consistent definitions of culturally and linguistically appropriate services in health care; and (2) to offer a practical framework for the implementation of services and organizational structures that can help health care organizations and providers be responsive to the cultural and linguistic issues presented by diverse populations.[7]

Although written primarily for health care facilities, the OMH guidelines have broad applicability to a variety of health promotion settings and are particularly applicable to community-based programs.

ROLE OF CULTURAL COMPETENCY IN PROMOTING ACCESS

Indeed, six of the CLAS standards were found to be directly applicable to community-based tobacco control programs and were commonly met by the PPI grantees upon evaluation. They were (1) recruiting a diverse and culturally competent staff, (2) providing language assistance services and interpreter services, (3) creating easily understood patient education materials and signage, (4) ensuring that clients received effective and respectful care, (5) developing participatory, collaborative partnerships with other members of community networks, and (6) developing a written plan that outlines clear goals and objectives. Viewed as a whole, the PPI community-based programs embraced a variety of processes to adapt existing, or create new, culturally sensitive practices and materials for their respective priority populations.

Figure 2 was adapted from Lurie's framework (2002)[11] to aid understanding of the connections among community characteristics, the social environment, culturally competent community interventions, and access to high-quality prevention and health care services. This flowchart highlights the critical role of community-based providers in enhancing access to high-quality care by ensuring the delivery of culturally tailored outreach and health promotion. By

using CLAS standards, measurable indicators were incorporated, which, in turn, strengthens the opportunities for replication and aids program evaluation.

USING SYSTEMS SCIENCE TO IMPROVE POPULATION HEALTH

Over the course of the initiative, PPI provided essential resources to underserved communities to help raise awareness of the toll of tobacco on high rates of morbidity and premature mortality for six identified populations. For many of the funded organizations, tobacco control had not been a high priority issue before their receipt of Legacy grants. PPI thus facilitated the process of bringing tobacco-related health disparities to the forefront of community-based activities. In addition, PPI enhanced organizational capacity and assisted grantee efforts to provide community-centered prevention and treatment services.

The sciences concerned with optimal population health and well-being have revealed just how broad the future world view needs to be.[5] PPI provided substantial support for building organizational tobacco control capacity at the grassroots level and fostering local collaborations. It also allowed organizations to introduce sustainable systems-level change to better serve clients seeking treatment of tobacco addiction. PPI provided substantial numbers of community-based programs across the United States with their first opportunities to implement grant-supported tobacco control projects tailored for their specific populations. However, much more remains to be done to reduce tobacco-related health disparities in the United States and throughout the world. Indeed, health has no borders. Thus, programs and policies to reduce tobacco-related health disparities must continually evolve to be responsive to culturally diverse and ever-changing communities at the local, national, and global levels. ■

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References

1. Merzel C, D'Afflitti J. Reconsidering community-based health promotions: promise, performance, and potential. *Am J Public Health.* 2003;93:557–574.

2. Centers for Disease Control and Prevention. Task Force on Community Prevention Services. Available at: http://www.thecommunityguide.org. Accessed July 1, 2008.

3. Schlaff AL. Lack of national primary care organization partnerships with community groups to promote health care reform. *Am J Public Health.* 2005;95:832–834.

4. Wells R, Ford EW, McClure JA, Holt ML, Ward A. Community-based coalitions' capacity for sustainable action: the role of relationships. *Health Educ Behav.* 2007;34:123–139.

5. Mabry P, Olster D, Morgan GD. Interdisciplinary and systems science to improve population health. *Am J Prev Med.* 2008;35(suppl 2):S211–S224.

6. *Breaking New Ground and Building Capacity in Cultural Tailoring.* Washington, DC: American Legacy Foundation; 2007. Available at: http://www.americanlegacy.org/2165.aspx. Accessed July 1, 2008.

7. Office on Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care.* Washington, DC: US Dept of Health and Human Services: 2008. Available at: http://www.omhrc.gov. Accessed July 1, 2008.

8. Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs–2007.* Washington, DC: US Dept of Health and Human Services; 2007. Available at: http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices. Accessed July 1, 2008.

9. Committee on Reducing Tobacco Use. Strategies, barriers, and consequences board on population health and public health practice. In: Bonnie R, Stratton K, Wallace B, eds. *Ending the Tobacco Problem: A Blueprint for the Nation.* Washington, DC: National Academies Press; 2007.

10. Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Board on Health Sciences Policy, Institute of Medicine. Assessing potential sources of racial and ethnic disparities in care: patient- and system-level factors. In: Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academies Press; 2002:125–159.

11. Committee on Guidance for Designing A National Healthcare Disparities Report. Measuring disparities in access to care. In: Swift EK, eds. *Guidance for the National Healthcare Disparities Report.* Washington, DC: National Academies Press; 2002:99–106.