Public Health And Health Care Reform: Implications For Family Practice

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I am very pleased to be a part of this outstanding panel and to share with you the celebration of the 25th anniversary of the American Board of Family Practice.

Much of my career has been devoted to the discipline of family medicine. I have enjoyed the practice and my personal role as a family physician. I have also enjoyed the opportunity to develop and to lead two very important residency programs in family practice, one at the King Drew Medical Center in Los Angeles and the other at the Morehouse School of Medicine in Atlanta.

I am delighted that, despite my departure from these programs, they continue to play an outstanding role in educating medical students in a discipline of family medicine and in the training of family physicians. These programs have contributed a great deal to the production of minority family physicians in this country since the mid-1970s.

Today I greet you as Director of the Centers for Disease Control and Prevention (CDC), and in that capacity I would like to speak with you about a topic that is very important to me and to many of us in public health. It is public health and health care reform with implications for family practice.

Evolution of Public Health

The discipline of public health has been challenged in recent years on many fronts. The Institute of Medicine in its report in 1988 described public health as being in "disarray."[1] Later, the American Public Health Association made a similar observation on the state of public health. Many agree that the present plight of public health is related, in great part, to the burden placed on public health at every level by the need to assure or provide access to health care for the underserved. As holes in the safety net of health care became larger, an increasing number of local and state health departments took on the responsibility for providing access to health care for the uninsured and other underserved. The energy and resources required to carry out this function have been devastating to our ability to promote the health of the public.

Under the Health Security Act, all American citizens and legal residents will be guaranteed a comprehensive package of health benefits.[2] This plan offers a specific set of preventive services, laboratory tests, and periodic checkups.

Some preventive services will be targeted to groups that have a high risk for certain diseases, such as men considered especially vulnerable to cardiac problems and women with a close family history of breast cancer. Children will receive a full range of prevention services, including immunizations, well-baby checkups, dental care, and developmental screening, at no extra charge.

Health care reform, by providing access to health care universally, also provides an opportunity for a new vision of public health, a vision that represents not only recovery, but reinvention, in light of new and emerging challenges and opportunities. A national vision of public health, during and after health care reform, must have several characteristics:

1. It must be clear enough to speak to state and local health departments, to schools of public health, and to programs of preventive medicine; it also must be clear enough to speak to communities at every level that must be involved in helping to promote health and quality of life and to prevent disease, injury, and disability.
2. Clear it must be — but the vision of public health must be sufficiently broad and complex to deal with the scientific, economic, political, religious, and social challenges that we

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face in removing a proverbial "handle from the Broad Street pump" to prevent today's threats to health. While we do not know how difficult it was for Dr. John Snow to remove the "handle from the Broad Street pump" in 1854 during a cholera epidemic in England, we do know that today it is not always easy to find or remove the "handle" that will stop the spread of an infectious disease, such as acquired immunodeficiency syndrome; environmental problems, such as lead poisoning; or a sociojustice problem, such as violence. It is not easy to find or remove the "handles" in these public health problems.[3]

3. The vision of public health after health care reform must be persuasive enough to garner the resources that will be needed to promote the health of the public. Currently core public health functions receive less than 1 percent of the health expenditures in the country.[4] The most conservative estimates tell us that this funding must at least triple in today's dollars for us to be successful in carrying out our responsibilities, which include surveillance of communicable and chronic diseases, control of communicable diseases and injuries, environmental protection, public education and community mobilization, accountability and quality assurance, public laboratory services, training and education of public health professionals, and leadership development.

In short, we are in the process not only of awaiting health care reform, we are in the process of reforming public health in this country. All available data on cost effectiveness or historical impacts of various interventions would suggest that this reform of public health will have a far greater impact on the health of people in this nation than will the reform of the health care system.

Clearly the dramatic gain in life expectancy for Americans within this century from 43 years in 1900 to more than 75 years in 1990 can be attributed mainly to public health intervention; furthermore, population-based preventive programs launched since 1970 are largely responsible for the most recent changes in dietary habits, blood pressure control, tobacco use, automobile safety restraints, and injury control measures that have fostered declines of more than 50 percent in stroke deaths, 40 percent in coronary heart disease death, and 25 percent in overall death rates for children.[5-10] These general outcome data are increasingly supported by cost-effectiveness studies showing the wisdom of dollars invested in population-based preventive programs.[11,12]

Public Health and Family Practice

We have come to a major intersection of the partnership between public health and the practitioners of family medicine. It is here that we must define a new relation between health care delivery and public health within which the two entities work intimately in a population-based approach to health protection and enhancement.

We at CDC and in public health look to family practice for a very important new partnership, a partnership to redefine the working relations between health care delivery and public health or prevention. Family practice traditionally has focused not only on the individual but on the family, and it has practiced prevention at the community level. This tradition makes family practice a natural partner, within the health care delivery discipline, for public health in efforts to bridge the gap between public health and health care delivery.

There are several important challenges facing both of us that illustrate this new partnership. The first I would cite is the prevention of domestic violence. We in public health are challenged to move such violence — between spouses, other partners, parents and children, adult children and elderly parents — out from behind walls of silence onto the public agenda. We need to make the subject one for society's attention, as well as the individual's attention. The family physician is often among the first to see symptoms that might indicate the threat of violence. Working together, we can make strides in primary and secondary prevention of injury and illness related to this visible and growing problem.

A second challenge is the immunization of children. At the national level we are dedicating major resources to establishing a system to ensure that all American children are protected against childhood diseases by the age of 2 years. As family physicians and as community leaders you can help us reach this goal as you promote prevention among your patients and your communities.

From that more global view of public health and health care reform, let me be more specific

about our own opportunities and challenges at CDC — challenges that result in a steadily evolving set of priorities for us.

Opportunities and Challenges

Strengthen Core Public Health Functions

We at CDC are committed to strengthening the public health system. As health care reform progresses, a major component in implementation activities is the development of a national, uniform health-reporting system that integrates public health and health financing data. This focus provides an excellent opportunity for CDC to examine our current information and surveillance systems and to position ourselves to meet the needs of public health while remaining compatible and consistent with the proposed new national reporting system. In light of this window of opportunity, CDC recently established a steering committee composed of senior level staff to describe an integrated nationwide public health information and surveillance system to gather, synthesize, and communicate information to monitor, promote, and improve the health of the public within the context of health care reform.

Another public health function is to provide training and education to public health officials. CDC provides such training to state, local, and international officials. I recently participated in the third annual Public Health Leadership Institute for state and local health officials. This year-long scholars' program provides public health officials with the knowledge and skills needed to determine local public health problems and to develop locally viable efforts to address them.

Enrich Capacity to Respond to Urgent Threats to Health

Infectious disease threats have continued in the past year. The epidemic of a newly recognized fatal illness caused by a hantavirus spread by rodents[13,14] and the outbreak of severe *Escherichia coli* 0157.H7 infection traced to hamburgers sold by a fast-food chain showed us once again the importance of human and laboratory resources required to meet such public health emergencies.[15-17]

Environmental threats persist, and public health agencies must be ready to recognize and prevent deaths and disease related to widespread use of food supplements, such as L-tryptophan,[18-20] and contamination of water supplies.[21] In the recent Milwaukee outbreak, 370,000 persons became ill in a single month after drinking water contaminated by *Cryptosporidium*, and about 50 died. More than $54 million was spent to address this epidemic.

Violence has reached epidemic proportions in this country. Every year 20,000 persons die from homicide, and 30,000 die from suicide. Youth violence is a particular concern. Homicide is the second leading cause of death for young persons aged 15 to 34 years and is the leading cause of death for both young black men and women in that age group.[22,23] The CDC strategy is to determine scientifically the factors that put persons at risk for violence or protect them from it, disseminate information about current programs for preventing violence, and evaluate potential interventions for violence prevention.

Tuberculosis is an urgent, reemerging health threat. After three decades of decline, reported cases of tuberculosis have increased in the United States by 20 percent and then, responding to new efforts, dropped in most recent studies.[24] Deterioration of the public health system, tuberculosis cases associated with human immunodeficiency virus (HIV), tuberculosis cases in foreign-born persons, multidrug-resistant tuberculosis, and a rise in transmission of tuberculosis in hospitals, prisons, and homeless shelters, all have contributed to this growth. CDC has greatly increased its TB prevention activities, particularly the support it provides to state and local health departments.

Workplace safety is an issue that we have been hearing about recently in the news, and homicide is the leading cause of occupation-related deaths for women.[25] The CDC is studying other important occupational issues, for example, occupational asthma and musculoskeletal disorders.[26,27] We are also building surveillance systems and designing intervention strategies to prevent farm-related diseases and injuries.

Develop a Nationwide Prevention Network and Program

Improving health requires that the CDC develop effective prevention programs and support the efforts of state and local officials as they plan prevention in their communities.

The President's Childhood Immunization Initiative promotes one of the most effective and efficient nationwide public health programs.[28] CDC is working with the Kiwanis, Rotary, and other civic groups throughout the country to make the goals of this initiative a reality.

Another effective prevention program is comprehensive school health education. Rigorous studies have shown that comprehensive school health education is effective in reducing the prevalence of risk behaviors among young persons.[29]

CDC uses health communications to prevent the spread of HIV infection. Last fall the CDC launched its Prevention Marketing Initiative designed to educate and inform young adults of the risks of HIV and the measures they can take to protect themselves.

The CDC Office on Smoking and Health is also an innovator in the health communications field. National efforts to communicate the harmful effects of tobacco use have led to a decrease in the percentage of Americans who now smoke.

While CDC has many programs already in place, some have yet to be implemented nationwide. We also need to look at prevention strategies in areas new to CDC and inform the public when new information is available on prevention of these conditions.

Promote Women's Health

The CDC is focusing on seven of the most important health issues faced by women at every stage of their lives, and there are prevention programs throughout the agency dedicated to women's health. For example, through our National Breast and Cervical Cancer Early Detection Program, the CDC helps state departments develop an effective prevention program.[30] Thirty states now participate at some level to provide community-based screening services to women at risk, expand outreach, and improve quality assurance measures for screening mammography and cervical cytology.

Closing Remarks

We will face great challenges in the months and years ahead, not only to continue our strong commitment to developing and implementing effective prevention programs, but also to ensure that we are able to articulate and quantify the success of our prevention strategies. We must lend our voices to the debate to ensure that public health and prevention remain an integral part of health care reform. If we are successful, we will have greater opportunities for improving the health of the American people than ever before.

On the occasion of the 25th anniversary of the American Board of Family Practice, I am very pleased to have been a part of this program and to have the opportunity to call for a new partnership between family practice and public health. This partnership builds on the shared commitment of public health and family practice to look beyond the individual to the family and the community in which individuals must live and grow. If we are to protect the future health of individuals, then we must enhance the environment for the family and community and to make those environments safe, nurturing, and healthful. We look forward to working with you as we move our health protection and enhancement efforts to a new level and as we focus on the future and on the community.

References

1. The future of public health. Committee for the Study of the Future of Public Health, Institute of Medicine. Washington, DC: National Academy Press, 1988.
2. Health security act. 103d Congress. Washington, DC: G.P.O. Supt of Docs, 1993.
3. Etheridge EW. Sentinel for health: a history of the Centers for Disease Control. Los Angeles: University of California Press, 1992.
4. Satcher D. Statement before the Committee on Appropriations US Senate, March 16, 1994, Washington, DC. In press.
5. Quality of life as a new public health measure — behavioral risk factor surveillance system, 1993. MMWR 1994; 43:375-80.
6. Daily dietary fat and total food energy intakes — Third National Health and Nutrition Examination Survey, Phase 1, 1988-91. MMWR 1994; 43:116-7,123-5.
7. Prevalence of adults with no known major risk factors for coronary heart disease — behavioral risk factor surveillance system, 1992. MMWR 1994; 43:61-3,69.
8. Cigarette smoking among adults — United States, 1992, and changes in the definition of current cigarette smoking. MMWR 1994; 43:342-6.
9. Special focus: behavioral risk factor surveillance — United States, 1991. MMWR 1993; 42(no. SS-4): 1-30.

10. Child passenger restraint use and motor-vehicle-related fatalities among children — United States, 1982-1990. MMWR 1991; 40:600-2.
11. Public health focus: effectiveness of disease and injury prevention. MMWR 1992; 41:265-6.
12. A framework for assessing the effectiveness of disease and injury prevention. MMWR 1992; 41(no. RR-3): 1-12.
13. Outbreak of acute illness — southwestern United States, 1993. MMWR 1993; 42:421-4.
14. Hantavirus pulmonary syndrome — United States, 1993. MMWR 1994; 43:45-8.
15. Preliminary report: foodborne outbreak of *Escherichia coli* 0157:H7 infections from hamburgers — western United States, 1993. MMWR 1993; 42: 85-6.
16. Update: multistate outbreak of *Escherichia coli* 0157: H7 infections from hamburgers — western United States, 1992-1993. MMWR 1993; 42: 258-63.
17. *Escherichia coli* 0157:H7 outbreak linked to home-cooked hamburger — California, July 1993. MMWR 1994; 43:213-6.
18. Update: eosinophilia-myalgia syndrome associated with ingestion of L-tryptophan — United States, through August 24, 1990. MMWR 1990; 39:587-9.
19. Analysis of L-tryptophan for the etiology of eosinophilia-myalgia syndrome. MMWR 1990; 39: 589-91.
20. Update: analysis of L-tryptophan for the etiology of eosinophilia-myalgia syndrome. MMWR 1990; 39: 789-90.
21. Surveillance for waterborne disease outbreaks — United States, 1991-1992. MMWR 1993; 42(no. SS-5):1-22.
22. Mortality patterns — United States, 1991. MMWR 1993; 42:891,897-900.
23. Use of race and ethnicity in public health surveillance: summary of the CDC/ATSDR workshop. Atlanta, GA, March 1-2, 1993. MMWR 1993; 42(no. RR-10):1-16.
24. Expanded tuberculosis surveillance and tuberculosis morbidity — United States, 1993. MMWR 1994; 43:361-6.
25. Occupational homicides among women — United States, 1980-1985. MMWR 1990; 39:544, 551-2.
26. Occupational disease surveillance: occupational asthma. MMWR 1990; 39:119-23.
27. Occupational disease surveillance: carpal tunnel syndrome. MMWR 1989; 38:485-9.
28. Reported vaccine-preventable diseases — United States, 1993, and the childhood immunization initiative. MMWR 1994; 43:57-60.
29. Tolsma DD, Koplan JP. Health behaviors and health promotion. In: Last JM, Wallace RB, editors. Public health and preventive medicine. 13th ed. Norwalk, CT: Appleton & Lange, 1992: 701-14.
30. Update: National Breast and Cervical Cancer Early Detection Program, 1992-1993. MMWR 1993; 42:747-9.