

## FROM THE EDITOR

## The Case for the Health of the Public: Worth the Investment in Times of Economic Woe?

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In the backdrop of projected obesity trends hitting 40% by 2018, our per capita expenditure on public health programs continues to be flat. They are on the chopping block of “expendable” programs, waiting like other unsexy programs to be cut even more. After all, public health programs do not bring millions of dollars of pork barrel spending to a particular senator or congressperson’s district.

We have a long track record of reactionary programs. Indeed, it is easy to cut programs that fail to show instantaneous results. In President Obama’s health care reform, a considerable investment was made in preventative programs for the first time. These were promptly cut.

The inattention to public health programs was highlighted by the Malcolm Peterson Award winner, Karen DeSalvo, MD, who serves as the current public health commissioner for New Orleans.

Public health programs were designed to contain, investigate, and contain epidemics and environmentally associated diseases. In the era of commercialization, however, public health departments have not kept up with the burgeoning epidemics of obesity, hunger due to the unavailability of good-quality food, and lack of physical activity. In

addition, with the explosion of health data with electronic health records, there does not appear to be a concerted effort to link data from health records to public health programs.

To add to the systematic neglect of public health, we in the medical education community have also abandoned the public’s health in favor of the individual’s health. Residents and students are taught diseases in the context of the individual patient—not in the context of the disease within the framework of the community. Non-compliance is a favored term amongst us—the social framework of the disease presentation. The goals of therapy are not addressed in the setting of the individual in his/her community. Given the competing demands of duty hours and limited time for curricula, public health has a low priority among the scores of things residency directors “must” teach residents.

Public health was defined by Charles-Edward A. Winslow in 1920 as “the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal

hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.”

Almost a century later, this definition, with the addition of mental health, still holds. Today’s problems include violence, lack of access to healthy foods and housing, and early diagnosis and prevention—not of beriberi or pellagra or plague but obesity and sedentary lifestyle. This mixed in with the SARS epidemic and Hurricane Katrina makes the case for reworking our strategies toward the health of our people.

As the health system adapts to ongoing economic austerity, pay for performance, and the “electronification” of medicine, we have a unique opportunity to rebuild the system for the public’s health. This time we need to improve the individual’s health by first addressing the health of the community and empower the physicians who deliver care. The front lines of the public’s health are in our communities, physician offices, and school systems. We need to rewire and integrate our current primary care strategies into our public health programs.

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