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# THE MISSIONS OF SCHOOLS OF PUBLIC HEALTH

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R. Stallones "acid wit + caustic Tongue" neutralized, Storey suggests how a very good thing could become better, "our Schools of Public Health"
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PREAMBLE

First, I should tell you that I am not going to talk about the New Federalism. I never understood the Old Federalism. I have long believed that a child born in Mississippi should have equal opportunity for survival, education and health as a child born in Connecticut, and that to the extent that the principle of state's rights contributed to inequity, then state's rights were being purchased at the cost of human rights, and this price was too high. I was a child of the depression, and the central government offered us hope and it became our faith. On the other hand, perhaps a nation of 220 millions of people cannot be governed from Washington. Certainly much of our experience of recent years supports this view. The difficulty, of course, is to sort out the failures of ineptness, ideological error, and corruption, from the inherent deficiencies of a mammoth metropolitan state, and I am not wise enough to do that. Therefore, I return to the principle of equality of opportunity as the only satisfactory criterion by which to judge proposals or to evaluate programs.

We are currently enmeshed in a curious paradox: at a time when health and medical services in this country are so inadequate that they are a national disgrace, and when organization and structure offer the only rational basis for early improvement of the situation, the educational institutions to which we might best look for hope in resolving these problems, the schools of public health, suffer from severe image problems.

I have been unable adequately to account for the poor image of our schools. The Congress has certainly supported us well, and the general public, to the extent that they think of the matter at all, seem to respond positively to the idea of public health. Perhaps more than anything else we have brought this problem on ourselves. Only within a few obscure religious sects is self-flagellation practiced so intensively and enthusiastically as among public health professionals. I have heard the schools castigated for their shortcomings by an Assistant Director General of WHO, a former Surgeon General of the United States Public Health Service, by staff of HEW, and by any number of faculty of schools of public health. To present a recent example; in March 1972, a report of the Panel on Health Services Research and Development of the President's Science Advisory Committee appeared. The Panel Chairman is a distinguished faculty member at one of our Schools of Public Health. The report stated: "While it is clear that the total number of persons receiving any kind of formal preparation for running the country's $75 billion health care industry is quite inadequate, serious questions may also be raised about the quality of the candidates being attracted and the nature of the training available." The report develops the idea that as bad as we are, our contributions are vital and that large increases in financial support should be provided us, if we agree to re-orient our programs. I have, myself, in a spirit of

excessive helpfulness, succumbed at times to the temptation to call attention of other institutions to their deficiencies. Taken as a whole, these attacks have succeeded, I believe, in obscuring the truly remarkable performance of these institutions, and some time ago I made a personal vow that I would no longer sit passively and endure them unless:

1. A rebuttal would be positively disruptive or discourteous, or,

2. The criticisms were person-and place-specific and based on fact or experience. What I mean is that I would not propose that The University of Texas School of Public Health should be spared critical comment; but any dissatisfaction with our operations should not be permitted to support a sweeping condemnation of the set of public health schools at large.

Therefore my approach today is sweetly ecumenical. I have decided that my acid wit and caustic tongue shall neutralize each other, and any suggestions I may make are not presented as criticisms, but rather are based on a wish that some very good things might become even better.

First, let us examine the problems.

1. Medical care. Despite the fact that we, as a nation, pay more for medical services than any other country in the world, we do not, in any reasonable degree, receive what we are paying for. Many people receive so little care for their illnesses that medically they might as well be living in some developing country. No effective quality control exists with respect to the medical services that are provided, and no physician in this country is unaware of cases coming to his knowledge where diagnoses were grossly inaccurate, therapy unbelievably inept, and

no redress was accorded the injured. The method of rendering medical care in this country is so arranged that no one, no matter how wealthy or how favored, has available continuous, comprehensive health and medical care of the kind we know could be provided. No arrangement that is client-initiated and based on fee for service payment can conceivably develop this kind of care.

As for accessibility of care, one simple example illustrates the problem more graphically than all the data on physician-population ratios. Has anyone not experienced, or had experiences related to him, of encountering first on entry into a medical care facility a demand for proof of ability to pay? I can understand how people will tolerate many kinds of indignities, but cannot understand why this one has not fomented revolution.

2. Environmental health. We should stop apologizing for our inability so to manage the environment as to eradicate coronary disease, and even concern ourselves a little less with air pollution and solid waste management. Poverty, ignorance, prejudice, and discrimination are environmental factors that establish a breeder reactor for disease, producing more fuel than it consumes. I cannot present the multiple regression equation that orders their relative contributions, but we cannot wait for this to accomplish some beneficial social engineering. I believe that a society most notable for conspicuous consumption and waste, that permits a child to go hungry cannot survive. Those of us who are affluent are condemned to struggle with clogged freeways, polluted air, a despoiled countryside, and shortness of breath on minimal exertion. Just as no one receives excellent medical care, just as surely, no one lives in an environment that is even remotely as healthful as we know how to build.

Here, then, sketched in the broadest terms are the challenges that confront all of us in community health. Perhaps we might look at some solutions.

1. Medical care. The standard doctrine today is that the solution to the medical care problem is twofold:

a. Produce more doctors.

b. Develop more effective systems of medical care insurance.

The first of these is self-defeating. Since a physician shortage is not the cause of the problem, a greater number of physicians cannot be expected to be a remedy. This is like treating leukemia with a mustard poultice (real mustard, not nitrogen mustard).

As for the second, certainly removal of economic barriers to medical services is an essential step toward achieving adequate medical care, but this is only one aspect of the disorganization and fragmentation that are characteristic of this field. The specific therapy for disorganization is organization; for fragmentation, integration.

A minimum requirement of a system is that the elements be linked. A system for providing personal health and medical care services in a democratic society must have the following performance characteristics.

a. Equal and easy access for all.

b. Assumption of responsibility to provide the full range of services required.

c. The full range of services must include promotion of health and prevention of disease, and the system must assume the responsibility for initiating these services.

2. Environmental health. Here, too, solutions have been proposed from markedly differing veiwpoints. On one hand, some seem to believe that we can somehow return to an agrarian or sylvan existence in which organic vegetables, VW's, and geodesic domes are the overt representations of a healthful environment. A contrary view seems to state that many, if not most, environmental problems are either self-regulatory (i.e. self-correcting), or will be solved by the natural forces of inventiveness and resource exploitation that produced them. Almost any of our large cities, Los Angeles for example, is evidence that the self-regulatory aspect of modern urban environments, if it operates, will come too late to do much good. However, to move the entire population of Los Angeles, in a large caravan of VW buses, out to the desert somewhere to live in geodesic domes would not produce a particularly appealing environment. I believe that technological ills require a technological fix, all right, but I also believe that if the value orientation that guided priorities in the past remains unchanged, then no fix will ensue. Here the plea must be for a humanistic technology.

One may reasonably wonder why society should turn to eighteen small schools of public health seeking solution to their enormous problems. The answer, in part, is that there is nowhere else to turn. The medical schools are fully occupied grinding out doctors and the health science centers are dominated by the medical schools. Academic departments of behavioral sciences are theory factories and their faculties are not disposed to become soiled by exposure to real problems. Welfare people are beleagured by both payees and payors, and educationists are equally concerned simply to survive. The engineers may take the play away; they have long been up to their ears in some of the more mechanical

aspects of environmental deterioration and recently a field of health services engineering has been promoted.

The schools of public health are unique among educational institutions by virtue of:

1. The breadth of skills represented on their faculties, and especially the melding of physical, biological, and behavioral sciences.

2. The startling diversity of backgrounds of their students.

3. Their preoccupation with a central theme - human health and disease.

Here, as in no other environment, the ingredients exist to make a genuine stab at developing and testing solutions. To accomplish these aims, we need to learn better, much better, how to create multidisciplinary learning environments in which our faculties can learn to communicate with each other and to coalesce their many skills to attack these common problems.

I would also suggest to you that as I listen to my recital of problems and solutions, to many of you this should sound like an echo from years back of the things that were said by Nathan Sinai, Franz Goldman, Abel Wolman, and dozens of others who made their homes in schools of public health. We have had Billy Mitchell's in our midst from the beginning of our development. If I am to be flayed for the shortcomings of public health, I want to be given credit for prophets we have nurtured.

Many institutions have a better image than the reality warrants. Our schools have a much better reality than our image would suggest. We could spend effort on public relations activities to improve the image; I

think perhaps we should, but more important, I think, is to develop our abilities further than we have, to approach our tasks with the enthusisam and intellectual excitement that were characteristic of public health in the 1920's, and to understand our mission clearly and state it unambiguously. Then, I think, our image will take care of itself.

Coming to the end of this I am reminded that the title of this paper is "The Missions of Schools of Public Health," and that I have forgotten to mention them. That is much too easy and none of you would have listened. The missions are:

1. To provide an educational environment.
2. To conduct research.
3. To perform community service.

To what end? So the following functions may be served:

1. To educate the community at large as to what the members may do to be healthy.
2. To develop and manage environmental systems that will support people but not their diseases.
3. To assure the availability of personal medical services.

The clarity of purpose of the educational curricula of the schools of public health has been obscured by the proliferation of program-determined terminology. Surely the common aspects are more important than the differences between programs in public health administration, medical care administration, maternal and child health, public health nursing administration, hospital administration, and similar subsets. Without subscribing to the notion that administration is administration without regard for the environment within which it occurs, the

management of a program in maternal and child health cannot call for skills and attitudes so very different from those required to direct a medical service organization or a health department. Indeed, the mobility of our graduates after leaving school demonstrates the fragility of the premise on which these separatist curricula are based. The confusion is miraculously dispelled if we understand that our graduates and programs fall quite naturally into two categories: the practice of community health and the sciences on which community health practice depends.

1. Preparation for Community Health Practice

   a. The field of community health practice is
      - Health and medical services administration

   b. The purpose of graduate education in this field is to
      - Assist candidates to prepare themselves to be agency directors, including the chief administrators and their surrogates and deputies

   c. The agencies that serve this field are
      - Public health agencies
      - Voluntary health agencies
      - Medical care facilities
      - Medical services systems
      - Health and medical insurance organizations
      - Comprehensive health planning agencies

d. The commonalities are:

- ° Administrative and management skills
- ° Health and disease in human communities
- ° Public responsibility and accountability (Public Service)
- ° Comprehensive Health Planning (Toward an integrated system of health and medical services for a community)

2. Preparation in the Sciences on which Community Health Practice is based

- ° Behavioral Science
- ° Biostatistics
- ° Epidemiology
- ° Environmental Health Sciences
- ° Biology

These comments may not appeal to all of you. Perhaps some of you live in worlds that are more complex than mine. If you choose to disagree, I hope that you will find that this construct is unambiguous enough that we will understand clearly just what we disagree about, and that will represent a great advance over most of the discussions of the missions of schools of public health.