EDITORIAL

Today's Challenges to the Public Health Service and to the Nation

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Not long ago, General Norman Schwarzkopf stood before a joint session of Congress and proudly proclaimed that it was "a great day to be a soldier and a great day to be an American." I say, with equal fervor, that this is a great day to be a member of the Commissioned Corps of the United States Public Health Service. It's a great day to serve this nation.

PHS Leadership

For the first time since I became Assistant Secretary on November 11, 1988, all eight Public Health Service (PHS) agencies are staffed with permanent Directors or Administrators. Rear Admiral Everett Rhoades, Director of the Indian Health Service, and Dr. Frederick Goodwin, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, were in place when I came in. They continue to provide dedicated leadership.

Rear Admiral Robert Harmon, Administrator of the Health Resources and Services Administration (HRSA), came to the PHS from Missouri where he was the State Health Officer. Significant changes are occurring in HRSA under his capable direction.

Rear Admiral William Roper, who heads the Centers for Disease Control and the Agency for Toxic Substances and Disease Registry, was lured away from the White House. This former Health Care Financing Administrator is effectively using his many talents and skills in Atlanta.

Commissioner David Kessler, who was Medical Director of Montefiore Hospital in New York City, is demonstrating that the Food and Drug Administration is not a paper tiger. His background in medicine, law, management, and education superbly qualify him for his responsibilities.

Dr. Bernadine Healy, Director of the National Institutes of Health (NIH), came to her new position from the Cleveland Clinic, where she served as Chairman of the Research Clinic. Prior to that she was with the Office of Science and Technology Policy in the White House. Her strong leadership, clinical research background, and vision will move NIH powerfully toward the 21st century.

Our newest agency head is the first Administrator of our youngest agency, the Agency for Health Care Policy and Research. Rear Admiral J. Jarrett Clinton comes from within the PHS. His difficult challenge is to move AHCPR quickly into a leadership role in medical effectiveness research and practice guideline development and to expand the traditional health services research responsibilities formerly carried out by AHCPR's parent organization, the National Center for Health Services Research.

Since I became Assistant Secretary we have a new Surgeon General, Dr. Antonia Novello, who speaks out for us on a range of issues—particularly related to the abuse of alcohol and drugs.

I'm proud of each of them and pleased that the PHS was able to attract individuals of this caliber. They are outstanding for their recognized abilities and achievements and for their integrity. Each is well-qualified. It is an honor to be associated with them.

Vigorous, vibrant, and innovative leadership is required not only at the agency head level, but throughout the ranks of the Commissioned Corps, if the PHS is to play the critical role that it must.

That the Environmental Protection Agency is not a part of the PHS today is, in part, a reflection of the past failure of the Public Health Service to address the environmental health concerns of the nation aggressively. The recent transfer of the Maternal and Child Health block grant to another part of the Department is also due to past perceptions of status quo within our ranks. We will have to do better than that if we are to lead the nation to better health by the year 2000.

Today's Health Problems

On the flight back from a recent World Health Organization Executive Board meeting in Geneva, I jotted down a number of health issues that are of serious concern to the nation. It is easy to make a list of serious public health problems and less easy to identify the resources to meet the needs. Any list would probably include

AIDS,
infant mortality,
preventable chronic diseases,
violence,
drug use, and
failure to vaccinate against preventable diseases, including measles.

Although we are concerned about the health and wellness of the entire population, in the PHS we recognize the disproportionate share of disease borne by our minority populations, particularly black and Hispanic Americans. In addition, we have given too little thought to the special needs of women's health.

The immense burden caused by the Federal budget deficit becomes even more evident as we craft the PHS fiscal year 1993 budget request. Getting the deficit under control necessitates strong fiscal medicine that will have a chilling effect on our nation's ability to fund needed prevention and treatment services. We are in danger of falling behind Japan and other industrialized nations in supporting our brightest and best research scientists, who keep our nation at the leading edge—yes, the competitive edge—in pharmaceuticals, medical devices, and biotechnology applications.

Never before has the PHS been so challenged to do more with less by setting priorities and thereby putting resources where they will do the most good. We are pleased with President Bush's strong support for our 1992 research and prevention budget request, which is currently before Congress. The $105 million increase in the 1992 budget for Healthy Start to combat our nation's appallingly high infant mortality rate is particularly pleasing.

Health Services Reform

Health services reform has become a national preoccupation for good reason: our health care system is not working. About 87 percent of Americans enjoy the finest health care system in the world; they lack neither quality nor access to comprehensive treatment and prevention services. The other 13 percent, however—more than 33 million—lack health insurance altogether or are substantially underinsured. Many of them are employed persons and their dependents, whose employers do not provide insurance benefits.

Furthermore, all poor people are not covered by Medicaid. Many Medicaid eligible persons are unable to obtain needed services because our nation turns out insufficient numbers of primary care providers and, for many reasons, even fewer chose to practice in inner city and rural areas. Nearly two-thirds of our counties contain significant pockets of population that were classified by HRSA as serious health provider shortage areas. We are paying more and getting less. Our nation is spending more for health services than it should, and the patchwork of private and public systems results not only in service gaps, but in gross and costly inefficiencies. Our huge expenditures are not matched by exemplary national health outcomes.

A recent paper by Dr. Woolhander and Dr. Himmelstein indicated that about $100 billion per year goes into paperwork associated with billing and deciding who should pay. Even if the amount is only half what they claim, surely it's an area where no one gets his or her money's worth. Our system is out of control. It eats up dollars that are needed for those persons who are not presently insured.

In May, the American Medical Association held a news conference on health reform, and the May 15 issue of the Journal of the American Medical Association and its nine specialty journals included almost 70 articles on the subject. George Lundberg, MD, the editor of the journal, said that "the aura of inevitability is upon us and it is no longer acceptable morally, ethically, or economically for

so many of our people to be medically uninsured or seriously underinsured." I believe we can all agree with that statement.

Commissioned Officers must do all in their power to assist the nation in moving in the direction of basic health services—treatment and prevention—for all. Although there is presently lack of agreement as to how the nation should proceed, I am delighted to see that this is an idea whose time appears to have come. It cannot be done without finding a way to keep costs under control. Our nation would not be well served if current trends continue. By the year 2000, at the current rate of increase, health care services will use $1.5 trillion—21 percent of the Gross National Product. We must find a way to bring the 33 million uninsured and underinsured into a more cost effective system than currently exists.

Infant Mortality

The problem of this nation's infant mortality rates illustrates the interrelationship between access to health services and responsible behavior, a point made by Secretary of Health and Human Services Louis W. Sullivan. We recognize that each is essential if the nation is to reach the Healthy People 2000 objectives. Babies and children are our nation's most important product. A nation's infant mortality rate is a measure of its success in combating poverty, ignorance, and disease. We are dismayed that the United States ranks below 23 other countries in infant mortality.

A black child born in our country is less likely to survive his or her first year than a child born in Costa Rica or Poland. An American Indian or Alaskan Native baby is as likely to die during his or her first year of life as a child born in Czechoslovakia. This is especially troublesome because the Commissioned Corps has a major responsibility for Indian and Alaskan Native health. The current U.S. infant mortality rate of 9.1 deaths per 1,000 live births represents a remarkable improvement over the past. In 1918, when the U.S. infant mortality rate was sixth in the world, there were 77 deaths per 1,000 live births. By 1960, the rate was 26 per 1,000.

Much of the recent infant mortality improvement has been the result of improved technology rather than attacking root problems. In other words, we're not making healthier babies; we're simply saving more sick babies. Newborn intensive care and other technology enables us to keep low birth weight and otherwise damaged babies alive. However, we do this at immense short- and long-term cost to the nation.

Dr. George Graham said that "the most important part of solving any problem is first defining it." He used the example of polio. We used to treat it by giving patients crutches, braces, and eventually iron lungs. But once we isolated the virus, we were able to develop a vaccine. The problem with the way we approach infant mortality today is that we are trying to solve it with braces and crutches, using the same old approach we once used with polio. We haven't faced up to the real problem which Dr. Graham said is "fundamentally a social one." More than 40,000 babies born in the United States this year will die before they celebrate their first birthdays. Another 250,000 infants born this year will live to their first birthdays, but will become statistics of another kind. These unfortunate children will be born with or develop disabling chronic conditions that are lifelong and will deprive them of true independence. The preventability of these conditions heightens the immensity of the tragedy.

Why do we allow these things to happen? What obstructs our progress in preventing low birth weight and infant deaths? What needs to be done? First, every woman must have access to prenatal care early in pregnancy. For this to happen will require financing mechanisms that include all pregnant women. There must be enough providers. The services must be comprehensive and co-located. You and I can help see that this happens and as rapidly as possible. Second, every mother must subscribe to healthy behaviors. Tobacco, alcohol, drugs, and poor nutrition take a terrible toll. The motivation and behavior of mothers are as important as access to services. Good doctors and good medicine alone will not be enough to reduce the U.S. infant mortality rate to 4.7 deaths per 1,000 live births, the current Japanese rate. Our system, any system for that matter, can only help those who want healthy babies and are willing to do their part.

Members of the Commissioned Corps can exert an extraordinary influence in helping pregnant women produce healthy babies. Prenatal care is cost effective. The average cost of prenatal care and delivery, including hospitalization, for a nor-

mal delivery is $4,334. By contrast, our health care system spends between $14,000 and $30,000 per low birth weight child, primarily for intensive care during the infant's first year. The lifelong cost of health care and special educational services for low birth weight infants has been estimated to exceed $250,000 per child. Many of the 250,000 low birth weight babies born in the United States each year will never be independent.

Both teenage pregnancy and out-of-wedlock pregnancies are strong co-factors for low birth weight and infant mortality. They are more reliable indices than poverty itself. In fact, they are often the root of poverty and low birth weight. A marriage certificate may be the best health insurance policy for infant outcomes. According to Nicholas Eberstadt of the American Enterprise Institute, "If viewed as a medical condition, illegitimacy would be one of the leading killers of children in America." The statistics tell the tale. The incidence of low birth weight is more than twice as high for unmarried mothers as for mothers who are married. Unmarried white mothers had an infant mortality rate of 13.1 compared with 7.8 for married white mothers. Unmarried black mothers had an infant mortality rate of 19.6 compared with 14.7 for married black mothers.

The cultural aspects of sound maternal behavior and family support may even compensate for comparatively poorer quality of care. In one word, behavior is the key. For example, Mexican American mothers have a lower rate of prenatal care than both black and white mothers, 58 percent compared with 61 percent for black mothers and 79 percent for white mothers. However, in spite of their lower rate of early prenatal care, Mexican American mothers have better infant outcomes than blacks and whites, 8.8 infant mortality rates for Mexican Americans, compared with 9.0 for white mothers and 18.7 for black mothers.

Fernando Trevino of the University of Texas attributes this to the support Mexican American mothers traditionally enjoy from intact families and the coaching they get from their mothers and even grandmothers. It's interesting to note that the health practices of Mexican Americans deteriorate the longer they live in the United States. They're more likely to smoke, drink alcohol, use drugs, and eat fast foods. Worse, as they adapt to U.S. culture, their infant outcomes become more nearly like those of the dominant culture.

While poverty is usually considered a causal factor in infant mortality, Nick Eberstadt notes that Chinese Americans are far more likely to be poor than whites, yet their infant mortality rate is only half as high. He attributes better Chinese American outcomes to the fact that Chinese infants are a third as likely to be born out of wedlock.

The infant mortality rate in Japan is less than 5 deaths per 1,000 live births. Like Mexican Americans and Chinese Americans, behavior and access appear to be the key. In 1985, there were only 23 births to Japanese mothers less than 15 years old compared with 10,220 in the United States. Only 1 percent of births in Japan were to teenaged mothers, compared with 13 percent in the United States. Only 0.1 percent of Japanese births were to unmarried mothers, compared with 22 percent in the United States. In Japan there is universal access to health care, and most mothers received prenatal care within 2 weeks of registering with the maternal and child health centers. Ninety-nine percent of Japanese mothers begin prenatal care in the first trimester, compared with 76 percent of American mothers.

Frankly, little of what we can do will work unless we can help people to accept and understand their own personal responsibility. We will end our disgrace when we, as a nation, develop a comprehensive, sound approach to preventing high infant mortality and low birth weight. Good medicine and good doctors are not enough. Good behavior and strong family support without early and comprehensive prenatal care won't do the job either.

STDs, AIDS, and Casual Sex

Public health practitioners traditionally have been outspoken about certain unhealthy behaviors, while avoiding saying much about others. We raise our voices about the damage done by tobacco, alcohol abuse, drugs, poor nutrition, and lack of exercise. This is as it should be. Have we clearly said that casual sex is hazardous to health? Instead we have used a brace and crutch approach to sexually transmitted diseases (STDs) by maintaining STD clinics and treating infected individuals when they showed up with symptoms. Too often, however, we have acted as though behaviors leading to STD transmission were inevitable and somewhat beyond the purview of public health.

What if our nation had taken the position 26 years ago that the use of tobacco was inevitable? Nearly 40 million Americans who have stopped smoking because they got the message might have continued with their unhealthy habit. Thousands more might have died.

In the United States there have been more than 170,000 cases of acquired immunodeficiency disease reported. An estimated 1 million Americans are infected with the AIDS virus. Not long ago the agency heads met with me in a budget session to consider what more we can do to stop virus transmission and get the AIDS epidemic under control. We talked about our successes and where we are failing in our AIDS policies and programs. We acknowledged the importance of developing and licensing new medicines to treat opportunistic infections and the direct effects of human immunodeficiency virus, that expanded programs were needed to test promising vaccine candidates, that a safe and effective vaccine is still years away, and that prevention holds the greatest promise for controlling the epidemic both for now and for the future.

As we approach the 10th anniversary of this global pandemic, an estimated 40,000 to 80,000 new infections still are occurring in the United States each year. We know how the disease is spread. We know that the presence of other STDs enhances transmission. We know what people can do to stop transmission from one person to another. Yet, as the disease spreads, those of us attending the agency heads' meeting wondered whether we are giving the nation a clear prevention message. We agreed that AIDS and other STDs ravaging society are caused by a culture of permissiveness. Promiscuity or casual sex, whether between homosexuals or heterosexuals, is one of the root causes of AIDS transmission.

Casual sex is deadly. Are we willing to speak out about its adverse effect on individuals and society? Are we willing to evaluate its cost honestly? Do we have the courage to speak out against prostitution and to encourage enforcement of laws relating to this deadly practice? Prostitution largely affects women. Is there a more lethal form of abuse of women? Casual sex and prostitution are responsible for spreading the AIDS virus and other viruses, including HLTV 1 and 2, hepatitis B, herpes, and papilloma. Casual sex and the permissive behaviors depicted on TV and in our movies foster illegitimacy and teenage pregnancy. Casual sex contributes to poverty, low birth weight, neglected infants, and high infant mortality.

We have been somewhat shy about speaking out against teenage pregnancy and childbearing outside of marriage. We know they have a proven impact on ill health. We send out a loud and clear message to Americans that they need to jog, swim, play tennis, and ride bicycles. We've advised them to limit their intake of saturated fats and increase the fiber in their diets. And we've told them not to use tobacco or drugs and to go slow on alcohol. The results are encouraging. Many Americans are listening, maybe not as attentively as we'd like, but we've got their attention—as the health statistics verify. We do not seem to be making as much progress with the diseases and conditions in society that are linked to casual sex. We have not had a clear public health message. We have not been as committed.

We must unequivocally reject the premise that any behavior leading to illness and death is an individual matter that is not the public's business and, therefore, not appropriate for our wholehearted attention. Even though we do not see casual sex recorded on a death certificate or a coroner's report as the official cause of an infant's or an adult's death, it is our business. Primo Levi, writing in "Vested Interests," put it this way: "When we know how to reduce the torment, but do not do it, then we become the tormentors."

Let it never be said of us, as the official voice of health in America, that Public Health Service Commissioned Corps Officers were only witnesses and not warriors—that in the struggle to promote and advance the health of the nation, we failed to raise our voices on behalf of access to quality health services for all and for proven healthy behaviors.