EDITORIAL

One of the strengths of *Public Health Reports* has been its commitment to covering *all* fields within public health, from biostatistics to epidemiology to maternal and child health to community prevention. The current issue of the journal continues this tradition and begins a discussion on the future of public health in the next century.

In some articles, we revisit public health verities and reaffirm their relevance to today's conditions and situations. Who thought that there was more to be observed, learned, said, and taught about handwashing? Had we not as a society made clear the importance of this small, but effective, preventive technique? Apparently not, as Mohle-Boetani et al. demonstrate. What their study may also demonstrate is that public campaigns designed to change culture and customs may only change them in certain populations and for a short time. These and other findings challenge us to think about how to institutionalize social and behavioral change.

The basic public health tools of surveillance, monitoring, and evaluation are reaffirmed in a series of articles. So, too, is the importance of use of data for policy development and program design. Both the Martin et al. article on domestic violence and the Moore et al. article on TB-AIDS registries point out the need for policies that cross disciplines and involve multiple organizations and varied programs.

But much of this issue should set us to thinking about the future of public health—about changing institutional roles and responsibilities, about sharing responsibility with various and diverse partners, and about broadening not just the definition of public health but the interventions and interveners. Michael Stoto's piece is one of these, addressing the issue from the perspective of the Institute of Medicine, whose several reports on the future of public health have served as catalysts for much discussion, some angst, and some action. George Rutherford takes one aspect of those earlier recommendations and writes about how to make them operational.

Three articles, however, present the future in a way that needs much greater attention, demonstration, and evaluation. First, Dr. Julius Richmond, former Surgeon General and the only other Surgeon General besides David Satcher to simultaneously serve as Assistant Secretary for Health, gives us a retrospective on "Healthy People" from its inception under his leadership; he suggests priorities if we are to meet the goals of Healthy People 2010, the third stage of the Healthy People goals for the nation. David Satcher, our present Surgeon General, updates us on the initiative to reduce racial and ethnic disparities in health by the year 2010 by describing an important collaboration between Grantmakers in Health and the Department of Health and Human Services and all its agencies. The third part of this triangle is a description of the Models that Work Program of the Bureau of Primary Health Care of the Health Resources and Services Administration (HRSA), a program to improve access to primary care.

Taken together, these three articles present important approaches for public health practice and raise essential questions for the future. First and foremost is the use of outcome measures both to evaluate programs and policies and to determine investments. Healthy People's use of health status as the appropriate outcome measurement for health programs was both innovative and obvious—innovative because too many programs had presumed the utility of different interventions and assumed that process outcomes were the appropriate measure of success; obvious because the second half century of public health has been concerned with improved health status as opposed to elimination of disease.

Healthy People made credible the importance the Office of Public Health placed on health status. It made tangible the belief that concerted efforts among various sectors of the health and medical communities, and between states and the national government, could and would improve outcomes. It also gave us the tools to compare ourselves, one to another and over time. There has been much progress and many achievements because of Healthy People. David Satcher's article helps us understand how much more needs to be done and what kind of additional partnerships can help us achieve our goals. There is a powerful—indeed compelling—argument that disparities in health care in a robust democracy in a time of great material wealth are not just unacceptable morally and politically but are indefensible as a natural or necessary occurrence. By highlighting these disparities and using both a special initiative and Healthy People 2010 as vehicles for eliminating them, Dr. Satcher is putting the nation's goodwill, as well as our sense of ourselves as a nation, into the effort.

Taken together with the disparities initiative, the local Models That Work programs call on us to incorporate issues of poverty, bigotry, and culture into our calculations of what works, how, and why. Models That Work provide wonderful lessons in the need for and use of outreach, the importance of understanding and following cultural norms, and the benefits of incorporating various levels and types of providers in serving patients and communities.

What Healthy People now requires of us is a greater emphasis on community education and prevention. Clinical prevention is insufficient and often irrelevant in eliminating the disparities that face us.

We hope that readers will respond with ideas, comments, and proposals for the future of public health. ■