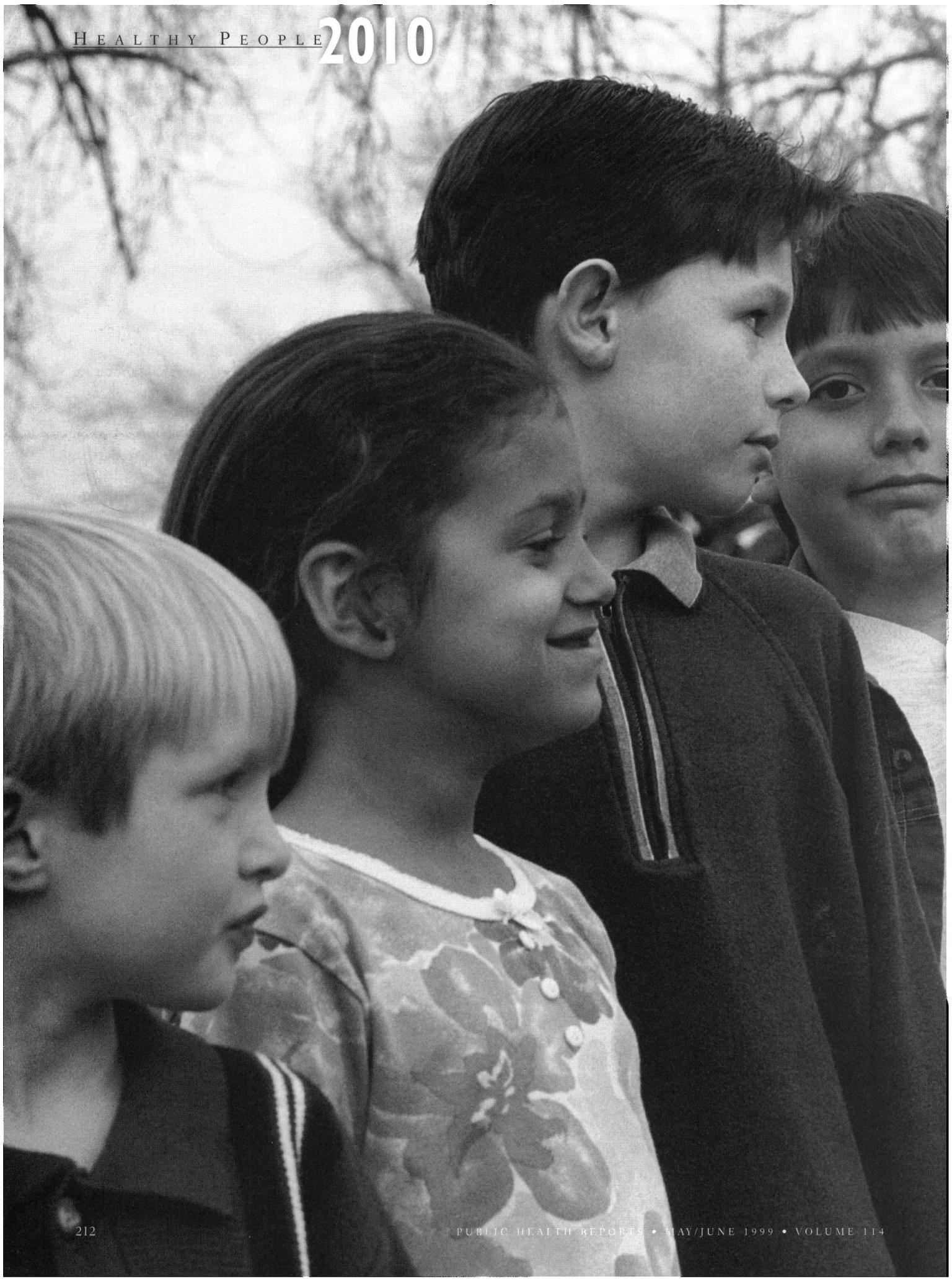
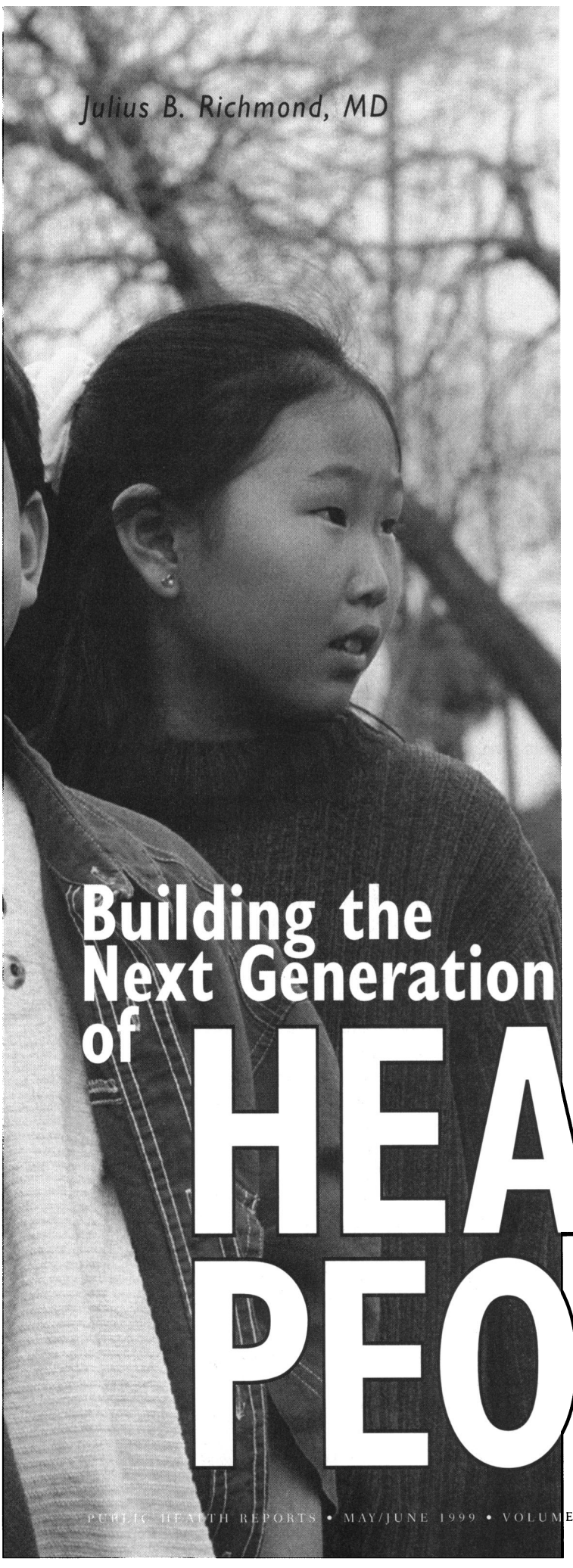




Julius B. Richmond, MD

Building the Next Generation of HEALTHY PEOPLE

Dr. Richmond, who was Surgeon General when *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* was published in 1979, is Professor Emeritus of Health Policy at Harvard Medical School. The following is an edited version of a speech given by Dr. Richmond at the 1998 Healthy People Consortium Meeting, November 12–13, 1998, in Washington DC. We are publishing Dr. Richmond's reflections as the first in a series of articles on the future of public health.—The Editors

If we could first know where we are and whither we are tending, we could then better judge what to do and how to do it.

ABRAHAM LINCOLN

INTRODUCTION: WHERE WE ARE

As we turn our attention to the next century and frame our overarching health goal for the year 2010 as "Health for All—Healthy People in Healthy Communities," it is well that we step back and review how we came to the process of setting these 10-year goals.

I became Surgeon General as we were three-quarters of the way through the 20th century. It strikes me that during this century we have witnessed a remarkable transformation in the health of our people:

• **We have observed a striking decline in childhood morbidity and mortality.** This has largely been the result of the decline in infectious diseases. Parenthetically, I would note that medical students in this country today will not see the children with acute infectious diseases who consumed more than 50% of my time in training as a pediatric resident!

Most significantly, we witnessed the successful completion of the World Health Organization (WHO) campaign to eradicate smallpox from the world. I had the privilege of leading the US delegation to the World Health Assembly of 1980, which announced the worldwide eradication of this devastating disease, one of the greatest achievements in the history of humankind.

But we cannot be complacent about our progress in controlling infectious diseases. HIV infections have emerged as a formidable challenge along with other emerging infections.

• **We have observed a significant decline in our infant mortality rate.** Although our trend is in the right direction, we have not made progress comparable to that of other developed nations. (I hasten to add that some of our states compare favorably to other industrialized countries.) Our task remains, therefore, as Surgeon General Satcher reminds us, to eliminate the disparities among the states as well as the disparities among ethnic groups. We have the knowledge; what we have lacked is the political will.

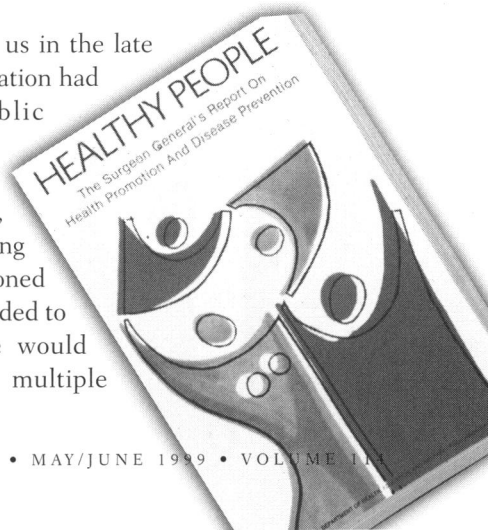
• **We have noted a significant increase in longevity.** While much of this could easily be attributed to the saving of life in infancy and childhood starting early in this century, we have also begun to see a saving of lives in the later years.

In the 1960s, many demographers didn't think we would see an increase in length of life beyond 65 years. But they have been proven wrong; the most rapidly increasing age group is people older than 80!

• **Most surprising of all has been the decline in mortality from heart disease and stroke** since the first Surgeon General's report on smoking and health. Many physicians had despaired of reducing mortality from diseases that were multifactorial in origin. Yet the public began to act on the knowledge that we had generated about the roles of diet, smoking, exercise, hypertension detection and treatment, and stress. The progress we have observed came as a result of education and behavior change—not because of medical care (although I don't minimize its importance). This has truly been a great advance in the public's health, and it should make us optimistic about the power of our expanding knowledge base in health promotion and disease prevention.

WHITHER WE ARE TENDING: A STRATEGY

It became apparent to us in the late 1970s that a transformation had taken place in public health. We were through the first public health revolution, and we were embarking on a second. We reasoned that new strategies needed to be developed. These would require dealing with multiple



factors; we would need to think of the long term.

Therefore, we decided to set goals for the next 10 years. We recognized that, in spite of the revolution in biology subsequent to World War II, the great advances in the public's health were largely the consequence of our progress in health promotion and disease prevention. The report we presented, which set 10-year goals for the nation, was titled *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention.*

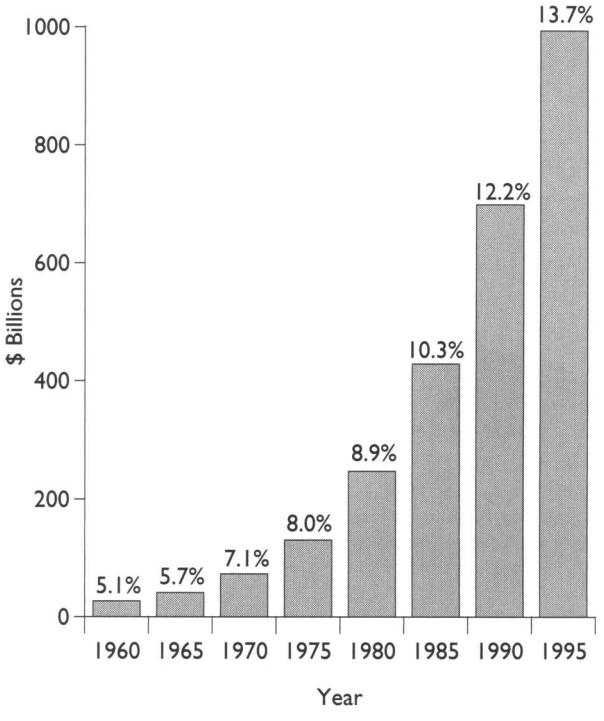
We are now into the third iteration of the report. The Public Health Service has institutionalized the process as one with a strategy of goals, analysis of potentialities, and programs for the achievement of the goals.

The transformation of public health requires new ways of thinking about health and disease. This approach involves our moving beyond diagnosis and treatment (important as they are) and beyond our well-developed efforts at disease prevention to an emphasis on health promotion or improvement in the quality of life.

Our health expenditures go beyond those of other countries, but these expenditures have not produced a better health record than in other developed countries (Figure 1). Yet it has become clear that we can lead longer lives of better quality if we continue to apply our growing knowledge of ways of promoting health and preventing disease. And if health professionals do not lead the way, others will. The considerable interest in alternative medicine certainly suggests that the medical and public health community is not meeting the public's expectations.

To deal with the complex interactions involved in health promotion, my colleague Milton Kotelchuck and I have developed a model for shaping health policy (Figure 2). This model illustrates the interdependence of our knowledge base, our political will, and our social strategy.

Figure 1. Total dollars and percentage of US gross domestic product devoted to health care, 1960–1995



SOURCE OF DATA: US Health Care Financing Administration, Office of the Actuary, National Health Statistics Group

WHAT TO DO AND HOW TO DO IT

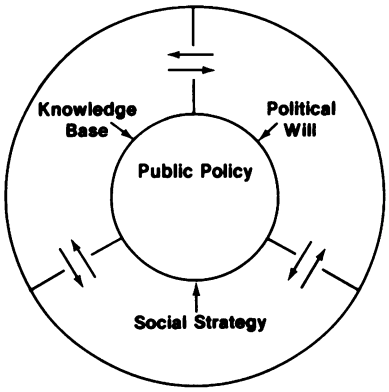
For the year 2010, the Surgeon General has already indicated a strategy for eliminating disparities in health and increasing quality of and years of healthy life (Figure 3). We clearly have disparities among population groups, by geography, by income, and by ethnic groups. For example:

- In 1995, the District of Columbia, the reporting area with the worst record in infant mortality had three times the rate of Massachusetts, the state with the best record. Mississippi's rate was one and a half times that of Maine—even though both are predominantly rural states. Certainly we should eliminate these disparities.
- In 1995, African American infants had more than twice the mortality rate of white Americans across all levels of mothers' education.
- The disparity in rates of prostatic cancer between African Americans and whites is unacceptable.
- The differences in trends in heart disease among ethnic groups and between rich and poor should be reduced.
- An unfortunate trend which we predicted in 1979—but didn't reverse—is the crossover from breast cancer to lung cancer as the leading cause of death among women as of the late 1980s. We told women that if they smoked like men they would die like men.

To increase the quality of life, we need to think boldly about reducing poverty and its health consequences. Poverty is a pervasive factor in accentuating all aspects of poor health. We despair too quickly at doing something about this basic inequity. Even though it seems an impossible task, the UN's development program has proposed a "decade for the eradication of poverty."

Let me suggest a consequence of poverty which is devastating: its impact on the development of young children. Years ago, in observing the development of young children being reared in poverty, we observed what we

Figure 2. Three-factor approach to health policy



SOURCE: Richmond JB, Kotelchuck M. Political influences: rethinking health policy. In: McGuire CH, et al. The handbook of health professions education. San Francisco: Jossey-Bass; 1983.

called developmental attrition—a progressive decline in the developmental test scores in the first three years of life. We also showed that this could be prevented with a comprehensive day care program. These observations formed the basis for the Head Start program, which I had the privilege of directing. All children should be entitled to be raised in an environment that permits them to be ready for school.

To pursue the Surgeon General's strategy further we need to focus on:

Promoting healthy behaviors. Many of today's major health problems are related to behavioral issues. Thus, smoking, diet, physical activity, alcohol consumption, substance abuse, and violence are issues which are of basic importance to the morbidity and mortality rates. These are issues which are multifactorial in nature and therefore have no instant or magic bullets. Programs to enhance healthy behaviors will require long-term strategies. Particularly for children, we must have long-term strategies appropriate for their age to help them learn to make healthy choices.

The Surgeon General's report on mental health, now in preparation, important in many ways, should help us to develop better strategies for dealing with behavioral issues.

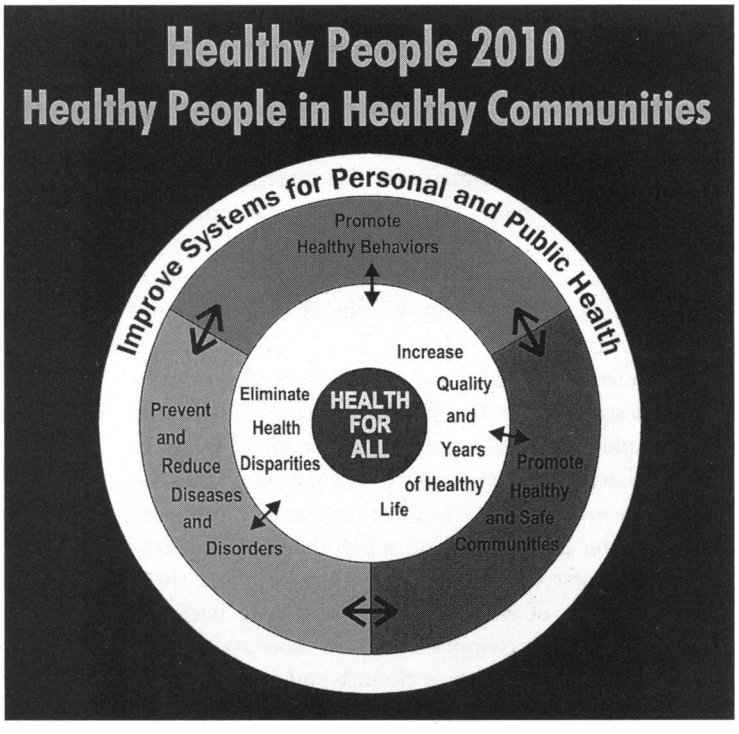
We must keep in mind that smoking is the single most preventable cause of death. Peto, a distinguished British epidemiologist, has emphasized that over the next 20 years, 100 million people worldwide will die from tobacco-related diseases and that tobacco is the cause of one-third of all deaths in people under the age of 70 in the US.

This suggests that we have not been really effective in developing our preventive efforts. The recent rise in teenage smoking reflects our ineffectiveness. The conclusion we can draw is that the tobacco industry *is* effective. The industry has good research (which of course they don't share with us) and the resources (about $6 billion per year) to enhance their programs for youth addition.

This provides the opportunity to point out that in the public health community we have not yet learned to use modern communication technologies effectively. Perhaps we need a Surgeon General's task force on modernizing public health education.

Prevention and reduction of diseases and disorders. We need to make personal health services more available and more responsive to our needs for health promotion and disease prevention. We need to continue to improve pregnancy outcomes and infant care. Family planning services, vaccinations, and services for sexually transmissable infections are dependent on the availability of high quality clinical programs. High blood pressure detection and control are basic to further reducing mor-

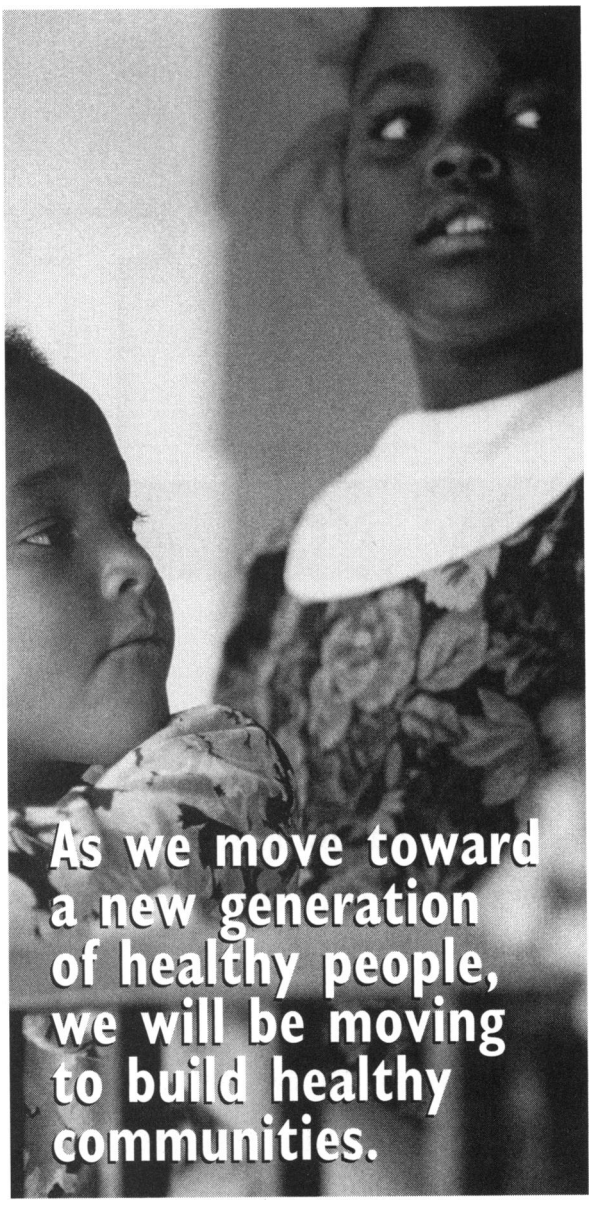
Figure 3. Surgeon General's strategy for eliminating disparities and increasing quality of life



tality from heart disease and stroke.

We have had an excellent Public Health Service report by the Task Force on Clinical Preventive Services to guide practitioners. The revolution taking place in the financing and organization of health services should not become an excuse for minimizing preventive services. We certainly cannot complete our agenda without developing a universal health service system which is all inclusive and fully utilized by those in need.

Throughout the life span we must develop health information programs which will have personal meaning—which will be internalized by each individual. This will become our best immunizing tool for the prevention of eating disorders and substance abuse while at the same time instilling sound nutritional, exercise, and mental health practices.



Promotion of healthy communities. Healthy behaviors are most effectively promoted in healthy communities. More emphasis has been placed recently on the need for comprehensive programs in communities. For example, in recent years we have seen a decline in violent behavior in many communities across the country. While many analyses of the reasons for this reversal of a trend have been offered, we have no clear answer since it probably results from a comprehensive approach in which we have done many things well and kept them in place long enough. (This is analogous to our reduction in mortality from heart disease and stroke. We still can't quantify which of the several approaches had the greatest impact!)

We need better population-based efforts to protect the public's health. Agencies such as the Food and Drug Administration (FDA) and the Environmental Protection Agency (EPA) have an important role to play. In the matter of tobacco use, for example, we have seen the long-term effects of the Public Health Service, through its Surgeon General's reports, in the gradual reduction of smoking. The FDA has played a major role in educating the public and in moving toward further constructive regulatory activity. The EPA continues to move us toward smoke-free environments.

But healthy communities are dependent on broad ecological efforts. Our urban and rural areas of poverty have been neglected and permitted to suffer dilapidation. Toxic dumps are too often associated with poor neighborhoods.

Thus, as we move toward a new generation of healthy people, we will be moving to build healthy communities. None of us is exempt from this effort, for it must be comprehensive and all-inclusive. We must continue our efforts to assure safe, fluoridated water supplies. I commend the Surgeon General in commissioning a report on oral and craniofacial health.

We have made progress in increasing our knowledge base. The recent proposals of additional support for the National Institutes of Health by the Congress indicate that we will continue these efforts. Our new knowledge coming from the Genome Project will give us much to contemplate—scientifically, clinically, and ethically. We need to continue to generate the political will for our programs to improve the public's health.

And through this effort to generate health goals for the year 2010, we are demonstrating we have the social strategies to enhance our efforts.

We have the resources to achieve the best health record of any country in history. With the leadership of Surgeon General Satcher, let us proceed to realize that goal. ■

Dr. Richmond is Professor Emeritus of Health Policy at Harvard Medical School and a former Surgeon General.

Address correspondence to Dr. Richmond, Dept. of Social Medicine, HMS, 641 Huntington Ave., Boston MA 02115; tel. 617-432-1410; fax 617-432-2565.