Public Health Statesmanship

By LEONARD A. SCHEELE, M.D.

I HAVE NOT the slightest hesitancy in announcing that I have plagiarized the title of this lecture: Public Health Statesmanship. It seems fitting, however, to inaugurate the Winslow Lectures with some reflections on this quality, this profession, this art of statesmanship—because Professor Winslow himself has exercised it in thought, word, and deed throughout his career.

In a symposium on Public Health Statesmanship at the University of Pennsylvania Bicentennial Conference in 1941, a symposium in which Professor Winslow participated, Dr. Parker Hitchens (*1*) quoted an unidentified passage which I wish to propose as the text of our discussion:

> "*History shows that great economic and social forces flow like a tide over communities only half conscious of that which is befalling them. Wise statesmen foresee what time is bringing and try to shape institutions and mold men's thoughts and purposes in accordance with the change that is silently coming.*"

This description of statesmanship gives us a good plumbline for our discussion. Note how it views the statesman as an embodiment of creative thought and action. Even the metaphor brings to mind a creative personality—the potter, guided by his vision, shaping and molding the clay.

This description also asks us to ascribe historical perspective to the statesman as one of his essential qualities. And, finally, it gives a central position in the arena of statesmanship to the economic and social forces which ultimately shape the course of events.

Criteria of Statesmen

Creativity—historical perspective—and recognition of economic and social change: We need especially to emphasize these criteria in our consideration of statesmanship in public health. The members of the public health profession come from many scientific disciplines. As professional workers, we tend to place the highest values on our technical knowledge and skills. But as statesmen, we are challenged to be something more than good technicians.

As technicians, we are called upon day after day to apply our special competence to problems of bewildering complexity. As statesmen, we are challenged to learn whence these problems sprang, to trace their deep, far-reaching roots, and to learn how other men have viewed the health problems of their day. In public health, each man's sphere of direct action may be narrow—confined by the limited reach of his individual technology. As statesmen, we are challenged to see the inseparability of our sphere from the countless interacting forces of society—and, having seen, to think and act as statesmen.

Professor Winslow's response to this challenge is woven into the fabric of public health throughout the world. I have more than a

Dr. Scheele is Surgeon General of the Public Health Service. *This paper, the first Charles-Edward Amory Winslow Lecture, was delivered at Yale University on November 14, 1952.*

spectator's reason for saying this. Recently, I have had occasion to dig into the story of public health in the past hundred years. As I picked up one thread after another and began to ravel it back to its origins, I found that Professor Winslow had been there before me as historian, as scientist, administrator, teacher, as prophet or philosopher.

Following such a leader, I find it difficult to bring you any original concepts of public health statesmanship. Nor does the subject lend itself to the closely reasoned development of a single theme, as would some technical aspect of public health. We are dealing instead with a kaleidoscope—the kaleidoscope of public health in the modern world. The same bits and pieces of modern society present themselves to us in an endless variety of patterns and problems. Our reflections, then, will be kaleidoscopic.

There is another difficulty. To discuss statesmanship is to discuss a human function. And it is a function fraught with the resolution of dilemmas, the making of decisions, and the exercise of wisdom, dedication, and leadership. These virtues are possessed in varying degree and are exercised consistently only by the uncommon man. Yet we of the public health profession must reflect upon statesmanship, must discuss it, and exercise it to the highest degree of which we are capable. For this is a period of history in which public health progress depends more upon the quality of our statesmanship than upon the specificity of our techniques.

I do not mean that our techniques are adequate to the solution of all our problems; nor that public health can relax for an instant its scientific effort for the discovery and development of better methods. Far from it. Nearly a century of organized public health work has proved the direct correlation of success with scientific advance and its resultant specificity of techniques. As public health progress has been based primarily upon the professional application of the biological and mechanical sciences in the past, so it will be in the future.

Nevertheless, the tide of events runs strongly in directions that should alert us to the challenge of statesmanship. America has entered a period of social evolution unlike any we have experienced hitherto.

The most obvious, and perhaps most potent, difference is America's position of leadership in the free world—a leadership which carries heavy responsibilities affecting every phase of our society and economy. It has not been easy for us to endure with patience the effects of prolonged mobilization. It has not been easy for us to accept the urgency of our defense problems or to learn the art of persuading other peoples to the benefits of mutual security and the principles of democracy. These are new experiences for us; yet they are essential for survival in a world threatened by Soviet imperialism.

Socioeconomic Elements

The economy itself is working in unfamiliar directions. I say "unfamiliar" because many people forget that the depression of the thirties is 20 years behind us, and that the pattern for solution of public health problems in the future is likely to be different from that of the past 20 years. Reasonable pressure for economy in governmental health programs is one of those forces that "flow like a tide over communities only half conscious of that which is befalling them." This will constitute a major challenge to our statesmanship. Public health programs will grow; but we must study needs, set priorities, plan better, and work harder.

Moreover, unemployment has reached a new low since World War II and American industrial production in September reached the highest point since 1945. Entirely new technologies have been added, or have replaced many prewar methods of production. Even more recent technological developments will bring about other changes in production. In agriculture, mining, and manufacture, the productive capacity of the individual worker has been more than doubled since the turn of the century. This enhanced productivity, coupled with the increased purchasing power of labor, has sustained a steadily rising standard of living. There is, for example, a startling difference in the variety and amount of foodstuffs which can be purchased today with a much smaller fraction of the workman's earnings, than 25 years ago.

The effects of these broad socioeconomic changes on public health are manifold, exceedingly complex, and ramiform. We may think

of public health as a state of community well-being or as an institution created by society to protect and promote that state of well-being. Actually, it is both; but however we think of it, we are bound to recognize a continuously interacting relationship between the health of the people and the economy; and a similar reaction between public health practice and the society in which it functions. These interacting relationships determine in large measure the nature of our problems.

I have mentioned the kaleidoscopic patterns in which those problems present themselves. Yet there is an order and a unity of purpose in public health work which make it the great institution it is and which enable its disciples to serve the environing society with compassion, with dedication, and with a sense of partnership.

To understand this motivation, we do best to turn to a classic definition of public health which was formulated by Professor Winslow in 1920 and which has been so widely disseminated that it may now be called the charter of modern public health:

> "*Public health is the science and the 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 services for the early diagnosis and preventive treatment of disease—and for 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*" (*2*).

Thirty-two years later, the Expert Committee on Public Health Administration of the World Health Organization adopted this definition as the basis of their discussions—with two minor changes which have a distinct Winslow flavor (*3*). They recognized an expanded concept of health education and changed "personal hygiene" to "personal and community health." Here at Yale, public health found the early expression and practice of this modern concept of community health organization and education, as well as many of its first recruits to the new group of health educators trained in that concept.

The WHO committee also added this phrase: "so organizing those benefits as to enable every citizen to realize his birthright of health and longevity." We hear in those words the echo of many a plea by Professor Winslow for a higher level of health than the absence of disease and for the universal application of public health benefits.

In our charter, then, public health workers may find many opportunities for statesmanship both in our most familiar programs and in those less familiar. Let us consider a few of them.

Environmental Health

Control of environmental hazards is one of the oldest public health functions. With a few notable exceptions, which I shall refer to later, that effort has been directed to the prevention of communicable diseases. Many of the traditional sanitary practices of public health are now quite commonplace. In fact, they are too much taken for granted. Yet as they developed, in their time, many a public health pioneer, a public health statesman, fought uphill battles against ignorance and fear to gain better understanding and acceptance of public health practice in the community.

Americans are living in an environment quite different from that of 50 years ago—or, for that matter, even 10 years ago. Public health can no more ignore this new environment as a possible source of ill health than our professional ancestors could ignore the environment of their times as a source of devastating epidemics. Moreover, we now think of the environment in a wider dimension—to include social and psychological factors along with the physical. The incidence of fatal and disabling accidents, for example, calls for the study of all these factors. The relationships of environment with mental health and such chronic ailments as heart disease, cancer, arthritis, and rheumatism also must be investigated.

Public health statesmanship requires that we recognize the health components in the new

environment. Often they go unchallenged, not only by the persons directly concerned with creating new environmental situations, but also, regrettably, by public health personnel.

The Chemical Environment

None of us, for example, can escape the influence of chemicals on our daily living. For the most part, that influence has been beneficial to a high degree. But in the field of public health, we are beginning to see clouds upon the horizon, literally. The problem of air pollution is no longer confined to our work places or to our largest industrial centers, but is a potential threat to health even in semirural communities where industries, domestic heating systems, and climatic conditions combine to produce serious "smogs."

It is significant to our reflections on public health statesmanship that in 1912 the New York State Commission on Ventilation, of which Professor Winslow was a distinguished member, was appointed by the governor at the request of the New York Association for Improving the Condition of the Poor. The association put up $50,000 for the work of the commission, especially in investigations of the relation of ventilation in tenements and schools to ill health.

In 1949, it was a local labor union that requested the Public Health Service to make a thorough study of the smog in Donora, Pa. Since that time, a number of community organizations have sought help in studying their air pollution problems.

Is it a measure of public health statesmanship that 40 years ago and again 3 years ago, it was not the official health agencies, but members of the society in which they function, who sought action in studying the health component of air pollution? If public health workers do not see beyond the performance of their prescribed routines; if they do not recognize the health implications of the new environment nor bestir themselves to interpret the problems to society, then we can say that their statesmanship in environmental health does not measure up.

Public health knowledge of chemical and radiation hazards began with the study and control of occupational diseases. Today the number of known substances, compounds, and processes used in industry runs into the thousands and is being increased day by day. To what extent the industrial uses of chemicals and radioactive substances affects the health of the general population is not known with anything like the specificity of our knowledge of occupational hazards.

The addition of chemicals to many processed foods and the development of new physical techniques for the preservation and transportation of foods also require study. The Select Committee of the House of Representatives to Investigate the Use of Chemicals in Foods and Cosmetics held extensive hearings in the 82d Congress and it is clear from the committee's report that more research is needed to determine the effects of chemicals in foods on human health. It is not clear, however, what the relationships between government and industry should be in the conduct of such research and in the formulation and enforcement of standards. Here is another instance in which statesmanship is, at the present time, more important for solution of the problems than the specificity of existing science.

Water Resource Problems

The pollution of our inland waters by industrial wastes is one of the largest domestic problems facing this country. It involves our total economy and is a present threat to industrial expansion, agriculture, recreation, fish and wildlife, and public health. We are still far from understanding the new types of pollution, as well as from solving this growing problem. During the past 4 years, the Public Health Service has worked with State and interstate water authorities and industrial groups to stimulate research. We are cooperating also with the Atomic Energy Commission in studies of the disposal of radioactive wastes. The current work, however, on both chemical and radioactive pollutants is only a small beginning of what is destined to become a large field of public health research and control.

Statesmanship in this field requires involving all the interested groups. For public health workers, it also provides a fine opportunity not only to interpret the health component in water pollution to persons primarily concerned with some other problem, but also to recognize and

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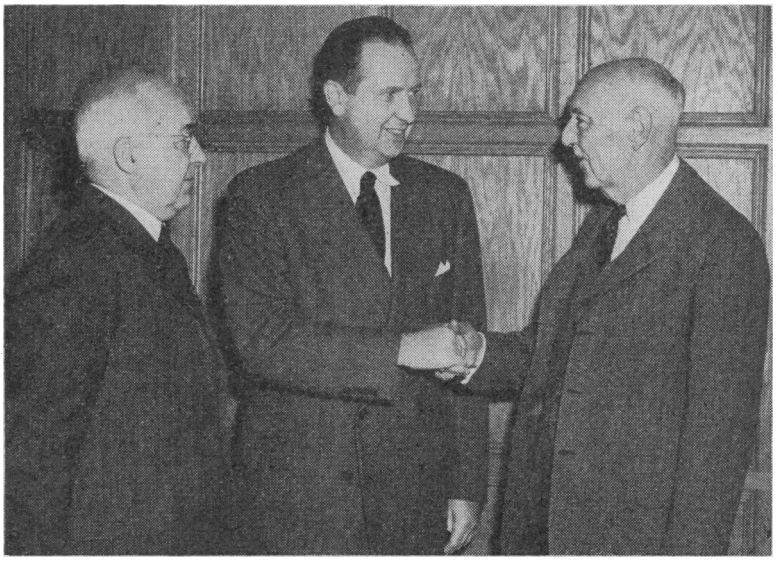

Dr. C.-E. A. Winslow (right) and Dr. Ira V. Hiscock (left), chairman of the department of public health at Yale, with Dr. Scheele on the occasion of the first of the annual lectures sponsored by the Yale public health alumni in honor of Professor Winslow.

Dr. Winslow is the Anna M. R. Lauder professor emeritus of public health at Yale and editor of the *American Journal of Public Health*. After training with Sedgwick, and with wide experience, he joined the Yale faculty in 1915 as chairman of the department of public health, retiring in 1945 after 30 years of service, during which he achieved international recognition as leader, teacher, and exponent of public health. In 1942 he received the Sedgwick Memorial Medal of the American Public Health Association "for distinguished service in public health." In 1952 he received a special Lasker Award from the Association, and the World Health Organization conferred upon him the Leon Bernard Foundation prize.

interpret the common interest of many diversified groups in the development and conservation of the Nation's water resources.

One of the valuable lessons we have learned is the greater efficiency of a team approach to the water resources problem. The team that public health statesmanship seeks, of course, is not a group composed solely of collaborating Federal agencies, but rather a group in which State agencies and others are fully participating members.

I cannot leave the problems of our chemical environment without reference to the fluoridation of public water supplies as a means of preventing dental decay. This is probably the first and only instance in public health to date in which a "mass sanitation" technique has been developed for the prevention of a noncommunicable disease.

The epidemiological studies of fluorine in natural water supplies and of artificial fluoridation have been classics. We in the Public Health Service have every reason to be proud of the work of some of our men in this field. Time will prove that this single discovery and development has been one of the great contributions to human health.

Like all innovations, fluoridation has met with resistance. And it is this very resistance that calls for statesmanship. In responding to something new, people forget facts long since accepted. They forget, for example, that fluorine exists in small amounts in many animal and plant tissues such as are found in the average diet, as well as in many natural waters. We have had varied reactions, from enthusiastic acceptance to uncertainty about the ingestion of fluorine, and even unfounded fear of "poisoning" similar to the early fear of the chlorination of water supplies.

Our statesmanship here consists in convincing the skeptics that our epidemiological and laboratory studies are valid and that the benefits of fluoridation are not to be discarded lightly in the face of uninformed opposition. Convincing is an art, and it permits no arrogance or contempt of the opposition's point of view. In convincing, we must be completely candid and interpret the needs for more research in this field. One of the core facts of public health is the continuous search for techniques even more effective than those which we can endorse wholeheartedly at a given time. This is one of the most difficult facts to interpret to the average citizen and to appropriating bodies; yet this

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task of interpretation is the very substance of our statesmanship.

Healthful Housing

There is one other environmental factor which as much as any other affects the solution of health problems as diverse as the control of heart disease, the promotion of mental health, and the prevention of acute infections. I refer to housing.

As Professor Winslow knows so well, as he has told us so many times, it is not enough that the American Public Health Association through his leadership has developed a remarkably accurate technique for evaluating the healthfulness of urban housing. Here is an instance in which the effectiveness of our techniques has exceeded the quality of our statesmanship.

Housing has been a major social problem of high priority throughout the world since before World War II. There has been tremendous enthusiasm and hope that housing and health agencies united could make substantial contributions to the solution of far-reaching problems affecting every family in the Nation. Yet few health departments have accepted their share of responsibility in working for more healthful housing.

At the present time, only 10 State health departments are actively assisting local health agencies in the development of housing programs. A few others have specific plans. Nearly 100 local health departments, however, have actively taken part in programs to improve housing conditions in the past few years. Only 13 States and 25 local health departments are conducting active programs in home accident prevention—closely related to housing. In States where progress has been made in either field, the responsibility for stimulating and assisting local activity has been delegated clearly to one staff member.

Statesmanship in the health aspects of housing calls for the active participation of local health agencies in community planning and the development of community housing programs. The fact that a city may have anywhere from 2 to 10 official agencies concerned with some phase of housing intensifies the challenge to be a public health statesman. The fact that some States have official housing agencies invites State health authorities to step across the street and make known their interest and their willingness to cooperate in joint solutions of a major social problem.

Disease Control and Health Services

It is indeed a part of public health statesmanship to reach out in the community and identify those social and political forces that will make common cause with us for the solution of health problems whatever they may be. I warrant that many a public health worker in State and local agencies today would be agreeably surprised at the diversity and strength of the groups ready and eager for his leadership.

In this connection, we need to help our boards of health and county councils develop public health statesmanship attuned to society's current problems. Public health workers read, talk, and listen to seemingly endless conferences all emphasizing the shift in the age composition of the population, the increase in chronic diseases and impairments, the needs for community facilities and for the mobilization of community health resources. I regret to say that much of this healthy exchange of information is between those already converted to the cause; and in rare moments of discouragement I wonder how much of the discussion goes in one ear and out the other.

Chronic Disease and Disability

Chronic disease, chronic impairments, and the disabilities of old age are indeed the major health problems of America's aging population. Even with the widest possible latitude in interpreting the laws authorizing Federal grants-in-aid for general health services, maternal and child health, and services for crippled children, we cannot expect existing, and possibly shrinking, appropriations for these purposes to carry a forthright attack on chronic disease and the health problems of the aging. Here we must depend upon the special programs which have been made possible by the demands of society for action against the first causes of death and invalidism.

There is strong popular support for chronic

disease control and for health services to the aging. Yet I would be less than candid if I did not say that State and local health services in most of these fields are scanty and scattered. Lacks of sufficient funds, facilities, personnel, and effective medical techniques are commonly cited as causes of the lag in health department activity. Another deterrent frequently mentioned is the resistance of physicians to any public health activity in these areas. I am sure that this occurs because of failure to explain properly the programs to them.

The measure of our statesmanship, then, need not be in convincing society that chronic diseases and impairments are health problems of the first magnitude. Society has already given its mandate—and gives it year after year—in support of our programs and of the voluntary agencies devoted to these special problems. Rather the measure of our statesmanship will be in convincing the medical and community leaders, in convincing boards of health, county councils and other governing bodies, that these health problems are social and economic problems of the first magnitude and worthy of their full support and action.

Once the interrelationships of chronic disability, old age, and economic dependency are clearly understood, there is every reason to believe that general cooperation in the development of community programs, in which all physicians cooperate, for prevention, as well as for care of the chronically ill, will be forthcoming. The development of health services, especially preventive and restorative programs, aims to reduce dependency and the costs of public assistance and public medical care. The possibility of sound economy sharpens the humanitarian impulse for cooperation and adequate support.

If health officials continue to represent their needs and the community's needs as encompassing no more than the limited public health programs of prewar days, they cannot expect the medical profession, the boards, councils, mayors, governors, and legislatures to recognize the changing health needs or to select the issues which require priority in the formulation of public policy. Public health statesmanship, in many respects, consists in raising our sights, in applying our technical competence to health problems wherever they exist and are being neglected. This implies, of course, that public health will also be self-critical, reviewing and appraising its own performance so that activities which no longer yield substantial benefits to the community will be modified or reduced in favor of more effort in neglected fields. It means also that public health must work more closely with the practicing physician and his organizations.

Promotion of Research

Scientific research has not yet given us the techniques we shall ultimately need for pinpointing the attack on chronic diseases or for developing a practical hygiene of the aging. At present, control of many chronic diseases is possible in the individual patient, but only through highly specialized skills and equipment. At present, medical rehabilitation of the disabled is possible in the individual patient, but only through specialized skills and equipment.

For these reasons, public health conducts and encourages a continuing search for simplified techniques which may be applied to the community as a whole or may be employed by the general practitioner in his office. For example, in cancer control we are searching for detection mechanisms that can be applied widely and inexpensively in effective case-finding programs. We are searching for cancerigenic agents in the environment, so that these hazards may be subjected to engineering, chemical, or other controls. In cancer, heart disease, arthritis and rheumatism, and many other serious ailments, we are supporting the unremitting search for therapies that ultimately may be placed in the hands of the general practitioner. Our goal in these present major diseases is not dissimilar to that which we have achieved in venereal disease control—with every private practitioner a "health officer," treating patients in his office; the health department maintaining supporting services of case finding, contact tracing, referral, and treatment of patients unable to pay for private care.

Obviously, we have not reached that point in the development of medical tools for such major problems as cancer and heart disease, comparable with serologic testing and penicillin therapy

in syphilis control. The nation-wide scientific effort in these fields and its accomplishments are another story, and one that is inspiring.

Society has made new demands on science since the war and has given science unprecedented financial support. We are all aware of how little money was available for medical research before the war. In less than a decade, the American people have reversed that condition in their determination to speed up the attainment of their health goals through expanded research. The essential leadership in the promotion of medical research has come direct from the public through their voluntary health organizations and their representatives in Congress.

The American Pattern

The development of the nation-wide effort in medical research thus has followed a characteristically American pattern: society leading, government aiding. Government aid to medical research has grown, but statesmanship from the outset has channeled the greatest part of that growth into the natural habitats of research—our universities, schools of medicine, and hospitals.

Cooperation of voluntary and governmental agencies with the universities and hospitals in medical research is a multimembered partnership. It has engendered mutual respect and greater skills in the solution of common problems. Science and society alike have benefited from this partnership in a vital area of research.

While new techniques for chronic disease control and hygiene of the aging remain in a twilight zone between experiment and universal use, it may be that this experienced partnership can speed the sound application of scientific advances. It may be that we need a "bridge" type of institution, with research, educational, and limited service functions, supported by many community, State, and national organizations.

New Partnerships

Certainly, in facing up to the specific problems of chronic disease and an aging population, it seems clear that public health needs to encourage and to develop many new types of partnership. One that seems of exceptional value is partnership with university schools of medicine. The foresight of Professor Winslow in keeping postgraduate education in public health at Yale an integral part of the School of Medicine has yielded rich returns. The department's cooperation with the city of New Haven further illustrates the value of this partnership between the university and the community's health services.

Recently the University of Buffalo School of Medicine released the first annual report of its Chronic Disease Research Institute. This project is an interesting experiment in new partnerships. The Public Health Service made available its Buffalo hospital which we were closing and which could be easily converted into the type of facility envisaged by the group of community health statesmen. The New York State Health Department provided a grant-in-aid, and entered into active cooperation with the university. Support for various departments of the institute came from the National Foundation for Infantile Paralysis, the New York State Association for Crippled Children, the New York State Department of Mental Hygiene, the Western New York Heart Association, and the Arthritis and Rheumatism Foundation. The governing board is chaired by the dean of the School of Medicine, and includes representatives from local hospitals, the New York State Department of Health, and the Public Health Service. An able staff has done outstanding trail blazing in its first full year of teamwork.

Let me quote from the report:

"The future plans of the institute are inherent in its purpose: to do research in the field of chronic disease, to discover better and faster means of returning the chronically ill to maximal living within their individual limitations and to teach these newer, better techniques for handling the most complex problems in rehabilitation to medical personnel throughout the Niagara Frontier. The University of Buffalo Chronic Disease Research Institute is a small but complete institution actively serving medical science and education within the community."

Would that there were more such small, complete institutions serving such a purpose within more communities where the problems of the

chronically ill have previously been neglected. Perhaps this modest beginning will give us valuable clues to public health statesmanship in this area. In the meantime, health departments must press on toward society's health goals through the organization of community resources.

Community Health Organization

The ideal of community health organization is nothing less than the mobilization of all the rich and varied forces within an American community in free and friendly association to combat a common enemy and to strive for the common heritage of health and longevity. Inspired by some of our educational institutions, notably the Yale Department of Public Health, the Nation's official and voluntary health agencies have learned a good deal about community organization in the past 15 or 20 years. To their credit, they have put into practice a good deal of this knowledge. The translation of the ideal into practice, however, is difficult as is any activity depending primarily upon interpersonal and intergroup relationships.

In community organization as in program planning and administration, public health officials need especially to be alert in preserving flexibility. If we recall our criteria for statesmanship, we will see why this is so: "Wise statesmen foresee what time is bringing and try to shape institutions and mold men's thoughts and purposes in accordance with the change that is silently coming."

Community organization merely to preserve the status quo of public health can be as stultifying and as far from meeting the needs as can the administration of programs designed for the same purpose. Moreover, community organization of this sort fails to tap fully the creative energies of the community. In particular, the natural leaders outside of professional ranks or in professions not usually associated with public health may possess the humane impulses and the very creativity needed for developing new types of service essential in the solution of our major public health problems.

I know of such a leader who wants to construct a new type of institution for the care of certain types of cancer patients. It will be a modern apartment hotel specially designed and furnished, constructed beside and with direct connections to a general hospital. The objective here is to provide efficiency apartments where family members or housekeepers may care for the patient in convalescent or other stages of his disease. Physicians would be at hand for routine supervision. When special therapeutic procedures must be carried out, the patient can be removed to the hospital immediately, and without loss of time and the added costs of an ambulance. More costly institutional facilities and services would be released for the care of more acutely ill patients.

This is a challenging idea, and one which may capture the interest of private enterprise, voluntary agencies, and religious organizations. It is an extension of the home care plan which has been developed so effectively by voluntary hospitals and agencies in a few parts of the country. We know that chronic disease and poverty go hand in hand, and that many times the home to which a patient would be returned cannot accommodate the needs of an invalid, no matter how willing the family may be to carry its share of the bedside care. Whether in a hospital-connected apartment hotel or at home, the costs of convalescent or terminal care of the chronically ill will be less than in a hospital. Hospital care for a patient costs three to five times more than care at home.

New and Effective Services

There are many other effective services that a community could provide for the chronically ill and the aging—services which not only relieve suffering and anxiety, but also bring about economies in the operation of public hospital and medical services. Some health departments around the country report housekeeping services, for example; but it is surprising how few communities have explored the possibilities. The New Haven Family Society, as I understand it, was one of the pioneering voluntary agencies to develop such a service.

The District of Columbia Health Department has developed a housekeeping service on a limited scale. Its primary purpose is to assist mothers in the postpartum period or in disabling illness. When these demands on its staff permit, however, the housekeeping service is available to aged persons.

Not long ago, an indomitable lady in her 80's suffered her fourth cerebral hemorrhage. The hospital insurance policy which she had carried for a number of years had been invalidated by previous hospitalization. Even had it been available, she did not want to go to the hospital because, she said, there was no one to look after her "boys"—an older brother and a mentally defective nephew of about 25 years. Here was a family that had never received a penny of public assistance; that owned its home; that managed to get along on the earned pensions of the two old people. The housekeeping service came to the rescue. And at least for 10 critical days when this family most needed help, there was someone to cook nourishing meals, do the laundry, keep the spotless home spotless, help the lady with her personal care, and, incidentally, save taxpayers the costs of hospitalizing her.

I have introduced this "human interest" story, because it exemplifies in many ways the human problems which make up the community problems, the public health problems; and it exemplifies the variety of human resources which must be called upon to help people meet their needs.

World Health

The mobilization of resources to meet human needs is the essence of world statesmanship today. It is in this international arena that public health workers meet face to face the inseparability of their sphere of activity from that of other specialists. Professor Winslow has been a world health statesman since the years of the League of Nations Health Section. He has been telling us all this while that public health does not and cannot function apart from the political, economic, educational, and cultural forces in whatever society it serves. Likewise, industry, commerce, agriculture, education, and government cannot function in isolation from public health.

Several hundred American public health workers are facing these interdependent problems today in their overseas assignments with the Mutual Security Agency and the Technical Cooperation Administration of the United States, and with the World Health Organization and other international agencies. Their statesmanship will be measured not alone by their skill in applying modern techniques to the solution of age-old problems in entirely different social and physical settings. Public health statesmanship in the world community also consists in understanding the drive of poverty stricken peoples toward a better life, and in ability to work with representatives of other governments and of such related fields as agriculture, education, industrial production, transportation, and communication.

Public health workers have invaluable knowledge and experience to contribute to the planning and conduct of programs for social and economic improvement in underdeveloped areas. Failure to take into consideration the health and medical aspects of any large-scale economic project may well lead to failure of the total plan. Here again, as in other situations I have mentioned, public health workers, as statesmen, must be alert to the health components in diverse social problems; must challenge disregard of health; and must exercise the arts of interpretation and communication in order that their technical skills may be used constructively.

Conclusion

In this somewhat random discussion, I have left untouched many specific problems in public health which call for statesmanship and many fields in which statesmanship of a high order is being exercised. I shall leave it to you to fill the gaps, for the qualities that make up statesmanship in the boundless field of public health are the same in each sector. Let the measure of our statesmanship now and in the years to come be taken by this yardstick:

> *"The objective of public health is not merely the prolongation of life but the increase of vigor, efficiency, and happiness of all the members of our complex society. . . It is no easy task that we have set ourselves, no task for those who fear opposition or criticism. Vested interests related either to economic profit or to prestige may stoutly bar the path to achievement. Even*

when these are not involved, we are confronted by the stubborn resistances of humanity to those new ideas and new forms of organization against which the average individual desperately defends himself. We must be wise and understanding as well as courageous. The tasks of the future cannot be solved by formulae alone; at point after point on the road there will be struggle in which wounds will be given and taken. Yet the objectives before us are so great that men of heart and courage will not hesitate to meet the risk. . . The road is long but the goal is worth the hazard. We need assume no unnecessary burdens nor needless quarrels. But when we are sure we are right, we must go ahead."

The time? 1936.

The place? The Milbank Memorial Fund Conference on Next Steps in Public Health (*4*).

The speaker? C.-E. A. Winslow—inspiration of this series of lectures—public health's great statesman.

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(*4*) Winslow, C.-E. A.: The next steps in public health: Review of the conference. New York, N. Y., Milbank Memorial Fund, 1936, p. 34.

International Certificate Requires Official Stamp

Health officers who do not have an official stamp to certify international vaccination certificates are requested to have a stamp made which includes the term "health officer" and the name and address of the health department. This stamp is required to attest to the signature of the immunizing physician, or physicians, affixed on the smallpox and cholera vaccination certificates entered in the new "International Certificates of Vaccination" form soon to be released. This document conforms with the International Sanitary Regulations effective October 1, 1952, and replaces the "International Certificate of Inoculation and Vaccination," PHS–731 (FQ), Rev. 12–48. No certificate is valid without the stamp of a "health officer." Public Health Service officers and medical officers of the Department of Defense will continue to use the seal of their respective service to authenticate these certificates.

Yellow fever vaccination certificates will be issued to the traveler at the time he receives his vaccination at one of the designated yellow fever vaccination centers. This certificate must carry the stamp of the designated clinic.