Public Health and the Public Agenda

Kevin Thurm

Thank you, Mr. McDonough, for that gracious introduction and, of course, for the opportunity to come home to New York.

People often remark that New York City is something of a microcosm of our nation as a whole. For that reason, I cannot think of a better place to have this conference. But even more, I cannot think of a better time to have it than now.

What today's presentations tell us is something that Secretary Shalala, myself—and our entire Administration—are aware of back in Washington. We are living through a remarkable—perhaps unprecedented—economic expansion: a time in which millions of jobs have been created, productivity is up, and the U.S. economy has firmly reestablished its vitality. I think Chairman Greenspan the other day used the phrase "truly phenomenal."

But while our economy has brought hope and opportunity to millions, we recognize how much more still needs to be done for many Americans. That is a particular issue for us at the Department of Health and Human Services. Because while many measure low incomes in dollars and cents, we also see them reflected in illnesses and injuries that go untreated—and in diseases, even deaths, that could have been prevented. We have seen these occurrences not only in our cities, but in Appalachia, the Mississippi Delta, and the reservations of Native Americans.

I would like to speak with you for a moment about the challenges that we face today—and about the demands they will place on us tomorrow.

In the time that I have been at Health and Human Services, one of the things I have learned is that the public health profession has quite a lot to teach policymakers. That is something many New Yorkers learned earlier this decade when Dr. Margaret Hamburg was New York City's health commissioner. Faced with a serious outbreak of tuberculosis, she organized a multipronged effort aimed at prevention, treatment, and long-term care. It was an effort that involved not only mobilizing health care providers in the field, but also policymakers in New York City, Albany, and Washington. And it was a success. Dr. Hamburg's accomplishment was all about making the right diagnoses, and carrying out the right plan of action.

Well, when public health professionals examine America's health, they see many, many strengths, but they also recognize some very serious symptoms.

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The good news, of course, is that Americans are living longer, healthier lives. Thanks in large measure to advances in public health, over the course of this century the average American's life span has increased by twenty-five years. Today, infant mortality is at an all-time low and child immunization is at an all-time high. We have even seen a decline in teen pregnancy. And, over the last several years, we have made dramatic inroads in our fight against AIDS, cancer, and other diseases. But there is also some disturbing news: too many are being left behind. Let me share a few statistics with you:

- Today, infant mortality rates for African-Americans are twice as high as they are for white Americans.
- Chinese-Americans are four to five times more likely to have liver cancer than other citizens.
- Latinos suffer diabetes at a rate twice the national average.
- The diabetes rate among Native Americans is three times as high as the national average. In fact, one-half of all the adults in the Pima Indian Tribe in Arizona are diabetic. That is the highest known rate in the world.

These are the symptoms. What is the diagnosis? We have known for a long time that an individual's risk of an early death rises as his or her standing in the social hierarchy falls. In fact, income is actually one of the strongest single predictors of mortality. This is what it really means when, despite the incredible economic gains we have made over the last six years, we say how much more we still need to achieve.

Today, 10.5 percent of Americans over the age of sixty-five are still living in poverty. African-Americans and Latinos are still roughly twice as likely as other citizens to live in poverty. Many of these Americans are likely to go to work at lower paying jobs, where they face more dangerous working conditions. And, as Barbara Wolfe points out, they are more likely to come home to substandard housing, as well. Furthermore, these conditions are often compounded by a lack of health insurance coverage. Today, more than 43 million Americans are uninsured. In New York City, approximately one in every four residents is uninsured.

How do these numbers translate into reality? Let me give you an example: Last year, in New York City 58 percent of uninsured women over the age of fifty did not receive a mammogram, compared with 33 percent of insured women.

But even more shocking is the plight of the roughly 11 million uninsured children in America today. Barbara Wolfe tells us that poor children without health insurance were more than two-and-a-half times less likely to see a health care provider over the course of a year than poor children with insurance.

At Health and Human Services, we have found that many of these kids come from families where their parents work, but earn too little to afford private insurance. And approximately four million are even eligible for Medicaid. But they are all uninsured. As a result, they are less likely than insured children to be immunized. They are less likely to receive preventive and primary care services. They are less likely to receive ongoing care for chronic illnesses such as asthma. And they are much less likely to receive treatment for injuries and diseases until they become serious.

That is why the Children's Health Insurance Program, or CHIP, was created. CHIP is a $24 billion commitment to provide heath insurance to millions of children growing up today in low-income working families. These are families that earn too much to receive Medicaid, but earn too little to afford private insurance.

To date, we have enrolled approximately one million children in CHIP. Almost every state, the District of Columbia, and Puerto Rico have been approved for CHIP funds. It is a true state-federal partnership. In addition, as with welfare reform, states have tremendous flexibility in this program, but that flexibility must also be balanced with accountability.

We want elected officials to make participation in CHIP by eligible families as easy as it can be. Accordingly, we are working with the states—and with the private sector—on outreach efforts, so they can help make sure that every eligible child is enrolled in CHIP. Our

efforts include a toll-free phone number, a new web site, and a national advertising campaign. The same goes for our outreach efforts on Medicaid. However, our diagnosis tells us that the issue is not just about insurance coverage.

The same commitment that led the President and Vice President to support CHIP also led to their challenge to all of us at Health and Human Services to take action to eliminate racial disparities in health. That is why, last year, Secretary Shalala and the nation's Surgeon General, Dr. David Satcher, set a very simple goal. We said that by the year 2010, America must eliminate racial and ethnic disparities in infant mortality, diabetes, cancer screening and management, heart disease, AIDS, and adult immunization.

In addition, we have asked Congress to invest $400 million over the next five years—in addition to our existing resources—to create public/private partnerships to replicate successful strategies. In particular, with the Congressional Black Caucus, last October the President announced specific targeted efforts to attack HIV/AIDS in the African-American and other racial and ethnic minority communities, where it is a severe and ongoing crisis. In fiscal year 1999, we have targeted $156 million on top of our ongoing programs and efforts.

We have undertaken this health-disparities initiative not only because it is morally right and just, and it reflects the evidence of where these diseases strike most severely, but also because we know that closing these gaps will lead to better health for all Americans.

That is the same idea behind our initiative to improve health care access for uninsured workers. The Administration has proposed $1 billion to strengthen community health clinics, public hospitals, academic health centers, and health departments—the health care delivery systems millions of uninsured Americans depend on.

But, I must tell you, no one suffers from any illusion about the significance of the obstacles we face. We realize that what we face goes beyond issues of income, health insurance coverage, or programs. It is also about providing access to culturally appropriate care as well as about informing, educating, and empowering Americans to take better care of themselves. These are two of the most pressing challenges—and opportunities—as we enter the twenty-first century.

First, with respect to the need for access to culturally appropriate care, in May 1996 the *New England Journal of Medicine* reported that poor African-American and Latino communities have roughly one-third fewer physicians as poor white communities do.

Simply put, we have an insufficient number of minority health professionals in America today. Now, some people do not accept that race should be an issue. They will tell you that a doctor is a doctor and his or her ethnicity should not make a difference. And they are right—it should not, but in truth, it does.

This is because minority health care providers are more likely to treat minority patients, and minority patients are more willing to see health care providers of their own race and ethnicity. This is also because when minorities do turn to our health care system today, they may be treated differently than whites. Earlier this year, a Georgetown University study found that physicians are far less likely to recommend sophisticated cardiac tests for African-Americans than for whites with identical complaints of chest pain. This is despite the fact that African-Americans are 40 percent more likely to die from heart disease than whites.

There is another factor. The ethnicity of the provider also makes an enormous difference when you take into account the fact that African-American, Asian-American, and Latino physicians are more likely than white physicians to treat Medicaid or uninsured patients in the same area. Today, nearly half of the patients seen by African-American doctors are either on Medicaid or are uninsured. That is one of the reasons why it matters that only 5 of every 100 doctors are Latino and only 4 of every 100 are African-American. We know from experience that those are the physicians most likely to provide the care African-American and Latino families so desperately need.

Accordingly, at Health and Human Services we have been working to help minorities make their way into the health professions. In our fiscal year 1999 budget, we invested more than $300 million in scholarships, loans,

financial aid, and other programs. But we cannot stop there.

We need to work with our primary and secondary schools to stimulate interest in the health professions among the young. We need to strengthen and promote the health sciences at historically black colleges and universities, Hispanic-serving institutions, tribal colleges and universities, and among Native Americans and minorities at other institutions. We also need to maintain our commitment to research so that we can better understand the reasons for different health treatment and outcomes.

Again, this is not about having some pie-in-the-sky ideas about social justice. It is about saving lives. Because our nation's health—our public health—is only as strong as the health of every American family.

The second challenge we face is to understand that effectively communicating health information with every American is also crucial to producing better health outcomes. The truth is that the vast majority of the health problems I have mentioned—problems like infant mortality, heart disease, cervical cancer, diabetes, and others—are, in large part, preventable and treatable. For example, we know that early detection and screening can reduce the risk of death from breast cancer by almost one-third—and that it can nearly eliminate the risk of death from cervical cancer entirely. But many minority women, especially African-American women, have never even had a mammogram or Pap smear.

We face a similar challenge in combating cardiovascular disease—particularly heart disease and stroke. For instance, we know that minorities have higher rates of hypertension and that they develop it at an earlier age. However, we also know that they are less likely to control their blood pressure once it is diagnosed.

But while hypertension and high blood pressure can be easily treated, there is little anyone can do until the individual fully understands the risks he or she faces and the options available. That is where education comes in. Now, sometimes the problem is obvious. For example, for a long time it was almost impossible to find a single informational brochure on mammography in this country written in Vietnamese. Now we have translated that information not only into Vietnamese, but also into Cambodian, Laotian, Chinese, Korean, and other languages. But if health education were simply a matter of handing out brochures, we would have won some of our battles long ago.

This is because what we are up against is not only a question of getting information into the hands of people who want it, but also helping to let people know that they need it. This is also true for older Americans, who already have coverage through Medicare. We know that less than 30 percent of women between the ages of sixty-five and sixty-nine are getting mammograms every two years. We also know that less than one-fourth of Medicare beneficiaries are receiving recommended tests for colon cancer. Research has also found that only a fraction of Medicare beneficiaries who should be vaccinated against pneumonia actually are.

But it is not enough simply to educate, we must also counteract the misinformation that permeates our nation as a whole, and often low-income minority communities in particular. For example, the tobacco industry has inundated minority communities with some of the most sophisticated advertising this country has ever seen. As a result, they have worsened a health crisis that is already difficult enough to respond to. It is part of the reason why African-Americans have the highest rate of lung cancer of any group in the country.

As Surgeon General Satcher points out, this is in part due to the fact that we have not effectively communicated messages about the importance of a good diet, quitting smoking, and regular exercise. Again, this is true for America as a whole, but for minority communities in particular. To paraphrase an old saying, "when America catches a cold, minority communities get pneumonia."

So we know that we are faced with more than an issue of income, coverage, and programs. It is about appropriate access: not only the lack of affordable health care but also the shortage of minority health care providers. It is about education: the fact that we are simply not effectively communicating health information. But, even beyond this, it is about the need for all of our institutions to keep pace with a whole series of profound demographic shifts in this country.

As I mentioned earlier, New York City is a lot like America. But, in many respects, America is becoming more like New York City. Because of that, the importance of these issues is only going to grow.

The shortage of minority health care professionals and our need to communicate more effectively become particularly critical when we consider the fact that, by the year 2020, more than one-third of Americans will be racial or ethnic minorities. The Hispanic population alone will rise from just over 11 percent to more than 16 percent. By the year 2040, members of minority communities will account for just under half of our population.

But this is not only about race. As the almost ritual debate in Washington over Social Security reminds us, we are becoming an older society: a nation where meeting the needs of the elderly—in housing, health care, nutrition, transportation, and other areas—is going to take up more of our individual time and our collective resources.

Now, responding to all of these challenges will not be done by the federal government alone. It is up to all segments: business, labor, religion, public schools, universities, as well as state and local governments. Most important, it will take leadership—particularly leadership at the most senior levels of public and private institutions.

What the science of public health tells us is that, just as a series of factors often contributes to the spread of disease, it sometimes takes different approaches to cure it. Almost 150 years ago, cholera was one of the deadliest diseases in England. At the time, no one had any notion of how to stop it. Well, one doctor had an idea. He was a doctor named John Snow.

Rather than attempting to treat every single case of cholera, Dr. Snow sat down with a map of London—a city where the disease had claimed more than 500 lives in one ten-day period alone. He laid the map on the table and began to mark the locations of all the homes of the people who had died. What he discovered was that the deaths had all occurred in an area called Golden Square—and that people in this neighborhood were drawing their drinking water from the same source. Armed with nothing more than a map and a pretty good hunch, Dr. Snow left his home and went to one of the water pumps used by the people in Golden Square—and he took off its handle. Once that pump was out of commission, the epidemic abated.

Today, there is not any single pump handle that we need to remove. There are many interventions necessary—and government cannot perform all of them. We all have to do our part because, more than ever, we know that a public health issue today can become an economic problem tomorrow. Funds that are not invested in preventive care now can grow to become huge expenditures for emergency-room care later. Tax dollars that otherwise might be used for education and for rebuilding our infrastructure instead are used to provide care for illnesses that could have been avoided. But this is not just a concern for the public sector.

Today, we know that the companies best suited to compete and win in the new economy will be those with a well-trained, active, and involved workforce. But ask yourself, how likely is it that any employer will be able to achieve that kind of stability when workers from half of our population—and their families—may suffer from untreated sickness and disease? In this respect, public health is not only a byproduct of economic growth—it is a precondition for it.

Let me leave you with the words of a truly great New Yorker. I am talking, of course, about Yogi Berra. Yogi Berra once said that if you want to change something, you have to change something. Well, I submit that it is our job to change something. To take the example of Dr. Snow to heart. And to make it our personal business to take the handles off of those pumps.

Thank you.