THE POLITICAL FUTURE OF PUBLIC HEALTH IN A TIME OF DEMOGRAPHIC CHANGE

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We do not customarily see public health as a primarily political activity, except perhaps when institutions such as the Environmental Protection Agency or the Food and Drug Administration propose regulations that threaten entrenched corporate or ideological interests. Most of the time, public health occupies a relatively quiet corner of the social contract—that is, what we expect from our government, our immediate communities, and each other, in fulfillment of the practical and moral obligations that underpin our national definition of a decent society.

But in times of major demographic, social, and cultural changes, or in times of severe economic distress, public health becomes a much more visible and important part of our political responses to these changes. And that is as it should be, for these upheavals have significant impacts on both public health and our political dialogues.

We are in the midst of such a time, and on the cusp of even bigger changes. I will argue in this paper that public health will have to join in the political fray, and should strive to return to the activism of an earlier era. I will further suggest that the public health establishment has not yet fully begun that task. By the "public health establishment" I mean all the institutional pillars of public health activity: federal, state, county, and city health departments; all of the academic schools of public health, and their teaching and research activities; the academic journals in which both faculty and public health practitioners publish scientific articles, editorials, and commentaries; and the great number of non-governmental organizations and philanthropic foundations whose work focuses on health, poverty, or both.

Finally, in these introductory comments: most of what I have called the public health establishment is already well aware of the great demographic shift that underlies our concern for the future. We are on the brink of becoming a "majority minority" nation, in which, for the first time, whites will be a minority and Hispanics, African Americans, and Asians will be, collectively, the majority. (Some demographers suggest that this has already happened). [1] And accompanying that change will come—or has already started—social, cultural, and (above all) political changes and struggles. In particular, we are already witnessing the intensification of the old arguments about the causes of poverty, the relationships of poverty to health, and the proper approach to responsive interventions.

A few cautions should be noted here about the reality of "white minority." First of all, white Americans will still constitute the single largest minority, and in economic and other ways, will continue to be more powerful than any other single "racial" or ethnic group, even if the white population shrinks further. More importantly, for most whites, "minority" status does not bring with it the meanings we have traditionally attached to that category for other groups—marginalization, exclusion, discrimination, and some degree of alienation.

Yet we are already experiencing the early political response to this change. Some 22 states have passed voter ID laws (a cure without a disease); early voting has been slashed; the Voting Rights Act has been gutted, and traditional minorities have been disproportionately disfranchised. Such efforts, along with gerrymandering, are usually attributed to a search for partisan advantage by both major political parties. Some scholars have suggested that something more may be involved: a defense of white privilege, a sense that the dominant position of whites in American society is eroding, and a biased feeling, fed by old and deep-rooted prejudices, that barbarians are at the gates. Part of this early political response, also, has been a striking intensification of old arguments about poverty and health. We hear, from highly placed political sources, that 47 percent of the population are dependent free-loaders, that the poor are shiftless, lazy, and unwilling to work, that there is a culture of poverty, and that it can be cured by suggesting that African American children be given janitors as their role models.

This long argument has been brilliantly reviewed in a book by Michael Katz, Professor of Sociology at the University of Pennsylvania, "The Undeserving Poor: America's Enduring Confrontation with Poverty." [2] Katz demonstrates that this argument dates back to our beginnings as a nation, and has been with us ever since. And that debate has been deeply conflated with that other enduring American conflict, over race and ethnicity. That conflict, too, remains current and persistent. The claim that we live in a post-racial society is a myth. The demographer Douglas Massey noted that hypersegregation of minorities persists, that residential and educational segregation continues, with only modest change. [3] Little noted, the most recent report from the U.S. Bureau of the Census found that 27 percent of all African American families live in poverty. [4] And so the poor remain relatively invisible—cyclically rediscovered by the rest of the nation only every 40 years or so—and so we remain trapped today in the same sterile debate: is poverty a personal flaw, or is it the consequence of structural and institutional forces, mediated by the things we now call the social determinants of health?

That argument is much older than the United States, and hardly limited to it. As most students of public health learn early on, in 1790—224 years ago—Johann Peter Frank, then the dean of an Italian medical school, gave a commencement address entitled, "The People's Misery: Mother of Diseases." With considerable epidemiologic sophistication, he spoke of bad and insufficient food, inadequate housing, the back-breaking work load of the rural peasantry, lack of access to medical care, and political powerlessness—the social order—as the cause of stunted and shortened lives, appalling infant and maternal mortality, and the constant burden of illness. [5] In 1839, another scholar from another discipline wrote, and I quote: "If the misery of our poor be caused not by the laws of nature, but by our institutions, great is our sin." Readers may be surprised by the author: Charles Darwin, writing in "The Voyage of the Beagle." [6]

In 1848, as this audience surely knows, Rudolph Virchow explained that the real cause of a typhus epidemic in Silesia was not the bacterial agent, but the social and living conditions of the

poor. [7] And in 1849, John Simon, the first health officer of London, wrote his first official report on the health of London's population. We will return to his words shortly. In the 1960s, John Galtung, a Norwegian sociologist, coined the term "structural violence"—not physical violence, but, "…the avoidable impairment of fundamental human needs," through "ubiquitous social structures, normalized by stable institutions and regular experience." Paul Farmer has added: "Because they seem so ordinary in our ways of understanding the world, they appear almost invisible. Disparate access to resources, political power, education, health care, and legal standing are just a few examples." [8] These authors are, in so many words, saying exactly what Frank, Virchow, and Simon said earlier: the deck is stacked, and poverty is institutionalized.

Why is this any of our business, those of us in public health and medicine? Because we now know so much about the health consequences of poverty, and about the damage that concentrations of poverty and ill health do to the larger society.

Perhaps we should begin our contribution to the political debate by focusing on children's health, particularly the health of children living in poverty. For decades, the U.S. has led the developed world in the percentage of its children living in poverty: 20 percent. (In New York City, that percentage has approached 25 percent.) Even before the worst of our Great Recession, the number of children living in extreme poverty, defined as half or less of the federal poverty level, had more than doubled. [9] Once again, we know that children in poverty experience bad housing and housing insecurity; bad food, hunger, and food insecurity; poor quality education and much less educational attainment; greater environmental exposures; a greater burden of disease and disability; and a sicker life and greater rate of premature death.

In addition, those of us in public health and medicine now know much more about the physiological mechanisms that mediate the translation of such poverty into disease. For example, we understand allostatic load: the ways in which constant stress floods the child's biologic systems with cortisol and other stress hormones, resetting the thresholds above which elevations of blood pressure, depression of immune responses, and disorders of a plethora of metabolic processes are triggered.

Two years ago, Dr. Nancy Adler and a roster of other investigators filled an entire issue of the Proceedings of the National Academy of Sciences with observations of the preliminary finding that, by age three or so, children experiencing poverty manifested observable changes in the structure of the cerebral cortex. [10] We do not yet know the relationship, if any, to the predictably damaged life course of such children, though many researchers now are exploring that question. But in any case, these findings—which drew little public attention—constitute a telling example of what Nancy Krieger has called the literal embodiment of poverty. [11] But such losses are more than personal and more than the concerns of public health and medicine. They are losses of the future contributions and productivity that childhood represents to the

larger society. And among those costs, we should not forget, are the immediate and staggering costs of the health care of such children, even if it is too often too little and too late.

Since all this is so clearly our public health and medical concern, how should we respond? We have studied, taught, and emphasized the social determinants of health for more than a decade. It is, by now, the topic of countless research articles, whole books on social epidemiology, scientific conferences, and reports by health-oriented foundations. But I submit that we have been too much talking to ourselves in all such efforts, and not doing enough to talk to the public. We have a specific contribution to make in the ongoing and intensifying political debate between those who argue that intervention and help to the poor is a moral obligation—and an effective one—and those who say it is a moral hazard, only encouraging dependence and laziness, bad both for the recipients and for the society at large.

Our task is to aggressively use all the ways we can find to tell the public the facts we know about the causes and processes that link poverty and health and, in multiple ways, damage our society. Of course I acknowledge that much of this effort has always been part of our work, and is ongoing, but I believe it is insufficient. We need to raise our voices in more public forums, give more legislative testimonies, write more op-eds and letters to the editor, aggressively insert our voice into the constant drone of contrary political views on the radio dial, and flood the blogosphere with facts. This will be an uphill struggle against ideological and partisan convictions already held by many, but it is a necessity. [12] In many ways, some of this burden has been met by NGOs (as in the video series “Unnatural Causes,” by California Newsreel) and by health-related foundations, and not enough by our academic centers.

To change that, we will have to produce a generation of public health workers who are politically effective advocates for social change, social justice, and human rights. Our messages should consistently counter the myth that government programs to reduce poverty and its health consequences do not work, by providing the facts. In the single decade of the War on Poverty, from 1965 to the mid-70s, the national poverty rate dropped from 22 percent to 11 percent. That is an astonishing achievement. Some of its legacies are still very much with us, in Headstart and in the national network of community health centers—some 1,200 of them, providing primary care at more than 9,000 sites to some 23 million people. They are one of the reasons the national poverty rate has climbed only to around 16 percent, and not higher.

Douglas Blackmon, the Pulitzer Prize winning author of “Slavery by Another Name,” has noted in a recent keynote address that such interventions stand in a long tradition of government efforts to help people find pathways out of poverty: everything from rural electrification programs to Hill-Burton hospitals, and all of the institutional constructions of the New Deal of the 1930s—and, like subsequent interventions such as Medicare, Medicaid, or current health care reforms, are under ongoing attack. [13]

There are other tasks that we might undertake. We in public health should be participants wherever community health workers are being trained, whether in community colleges or in existing medical care facilities—community health centers, community hospitals, and the like. Community health workers, fortunately, are making a comeback: they are our most effective links to the realities of poor populations, both to help manage interventions and to gather data.

Still another task is for academic public health centers, as well as health departments, to work collaboratively with institutions directly serving the poor, such as community health centers, but also with other governmental agencies in housing, urban development, and education. One such example is the collaboration, in the 1960s, of the collaboration between the East Boston Community Health Center and the epidemiologists at the Harvard School of Public Health. Together, they identified the prevalence of untreated ear infections in East Boston children, tracked those young patients into their school years, discovered the consequences of hearing loss to academic performance, and outlined needed interventions. Another is the current collaboration between Seattle's health department and a variety of clinical providers in changing the management of childhood asthma. Health department workers visited the homes of asthma patients (provided by the clinical facilities) to intensively train parents in the ongoing removal of asthma triggers, resulting in dramatic decreases in acute asthma attacks and health care utilization.

Yet another form of collaboration is the addition of pro bono lawyers to clinical teams by Medical-Legal Partnerships, whose national headquarters is based at the George Washington University School of Public Health. These lawyers deal with poor patients' additional stress- and illness-related problems: threatened evictions, utility cut-offs, wage theft, and other workplace abuses. Such efforts are more palliative than structural, but they can verge on the latter. And good evidence shows that, over time, the lawyers sensitize the clinical staff to these realities in their patient's lives.

I have, in this paper, conspicuously omitted much reference to the health care system itself, and its providers. This is mostly because there is little in the clinical encounter that will deal with social determinants. Most clinicians are not trained for it, do not have time for it, and are not reimbursed for such efforts. A recent foundation survey found that a high percentage of physicians, though fully aware of social determinants, felt helpless to intervene. [14] Nevertheless, the tasks I have urged stand in a long tradition. It was public health officials and clinicians together who led the campaign to end child labor in this country. It was public health workers and clinicians in New York City who helped to draft the nation's first tenement law, establishing minimal standards of space, air, and light for buildings housing the poor. Health departments in the past, as in John Simon's first report on the health status of London's population, have not feared to tell truth to power. [15] The fact that the health center my

colleagues and I opened nearly half a century ago in Bolivar County, Mississippi still flourishes today, under the ownership and management of the rural African American population it originally intended to serve, has similarly shaped the views I have expressed here. [16] In striving to make public health and medicine real instruments of social change, we stand on great shoulders.

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