

New Resources and New Alliances for Schools of Public Health

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The basic support for schools of public health has come from the universities of this country. This support has grown in recognition that public health is truly an area for scholarly development and professional preparation. It is significant that some of the foremost universities of this country have been the ones to start schools of public health.

The recent and rapid development and expansion of schools, which began about fifteen years ago, has reflected the inflow of federal funds. The number of students has grown from 1,230 in 1958, to 4,802 in 1972. Perhaps even more significant, the number of schools of public health has increased since 1960, particularly in the Middle West, where the number has grown from three to six, and in the West, where it has grown from one to five.

Institutional support to schools of public health was started by the federal government prior to its commitment to support schools of medicine, dentistry, osteopathy, and other health professional schools with capitation or other institutional funds. During this same period of time, of course, several major private foundations have also been supporters of schools of public health.

Now we enter a new era. The authority in the federal government for all institutional grant support in the health professions terminates in June, 1974. The Congress and the Administration are currently considering whether and in what form that support should be renewed. Dr. Wegman suggested that we can learn, from our friends in China, the slogan "serve the people." Perhaps we can also learn from the word "crisis," as written in Chinese characters which, I am told, mean "danger and opportunity." That precisely characterizes our situation at the present time.

National Trends

Congress is now disposed to take up health manpower training as a whole, rather than public health and other fields separately. This is frankly upsetting for many who have been engaged in education for public health who have come to rely on clear-cut and long-lasting support, for fifteen years, in the form of the Hill-Rhodes grants. It is now quite clear, however, that Congress is examining health manpower training as a whole, and is thinking about the interrelationships among various health manpower training programs.

This situation creates a natural alliance among the various health profession education groups, something which has not received much attention in recent years. We have taken a rather separate course and have not worried about such things as capitation grants for schools of medicine, dentistry, and osteopathy. As one of the staff members of a Congressional committee dealing with these matters remarked the other day, however, "You're all in the same bag now together." In this emerging natural alliance, I look for a considerably enhanced leadership role from the Association of Health Science Centers.

In the endeavor to secure new federal funds for schools of public health, there are varying types and degrees of support that can be developed in Congress and the Administration. As we seek such support, it would be highly desirable to have agreement on the precise form of legislative program that all of us in higher education for the health professions can join in supporting.

We are beginning to get another message from our friends in the Congress, namely, that any new support is going to exact some quid pro quo. In the past, we have enjoyed basic institutional support for schools of public health without great demands being put upon us. That was probably good and justifiable during the last fifteen years, when we were building up the number and strengths of the schools of public health. But now that the growth has been substantial, and though the nation may still need more schools of public health, there is going to be greater attention paid to what we are "doing lately" for public health. This may mean not only strengthening schools of public health generally, but also turning out specific kinds of professionals. For example, we may be expected to train health service administrators, just as medical

schools are now expected to train family practitioners. This shifting relationship between governmental support and output from schools gives us considerable concern, and we are going to have to deal with the matter quite carefully.

A number of other issues surround this central issue of federal support of schools of public health. One already mentioned has been the work of two commissions—the Milbank-supported Commission on the Study of Higher Education for Public Health, and the Kellogg-supported Commission on Education for Health Administration. These Commissions, the former concerned with the whole of education for public health, the latter concerned more specifically with health administration, may well give us some directions both for our work and for seeking support.

Some recent specific federal thrusts deserve attention. Some of us entered public health a few decades ago during national endeavors to control particular types of disease, for example, venereal disease and tuberculosis. Now we see a resurgence of categorical disease control programs: for cancer, heart disease, and respiratory diseases. In reviewing the National Cancer Program this past year, the Congress noted that the program was not sufficiently devoted to cancer control. Congressional inquiry focused to a considerable extent on the question, "Now that you are finding out all these wonderful things and are going to find out more, how about putting them into practice in the communities? What are you doing to assure that what is learned in medical centers will actually be applied even a few miles from them?" Congress gave a firm directive, which is being taken seriously by the leadership of the National Cancer Program, to move ahead rapidly in the direction of cancer control. To emphasize seriousness about this matter, the Congress increased funds for cancer control from five million dollars last year, to thirty-four million dollars this year. Thirty-four million dollars in the context of the total health budget may not seem like very much, but that rate of increase is certainly interesting. It hasn't attracted the kind of attention that it deserves in public health circles around the country. It appears that there will be similar thrusts in the growing national programs for cardiovascular and respiratory diseases.

Another federal thrust is toward international health. For example, several of the schools of public health have recently had

contact with a program, funded by the Agency for International Development and administered by the American Public Health Association, for the Development and Evaluation of Integrated Delivery Systems (DEIDS). Major emphases of DEIDS are: population, family health care, and nutrition, in developing countries. Again, while the total sum of money is not great, it is sufficient to link schools of public health with significant projects in developing countries.

A third new federal thrust is less concrete at the present time, yet it may be the most important of all. Beside the current excitement about medical care and protecting the environment in the interest of health, there seems to be a growing recognition that a third element is highly important to health advancement, namely, health behavior. Some people term this *health education*. I'm not sure that's the best word for it, but it is widely used in the field of public health. Personal habits—what one does every day—from the time he gets up in the morning until he goes to bed at night, how he eats and drinks, whether he smokes, how much he exercises, how he drives his automobile—are being emphasized as important for public health. Several decades ago Herman Biggs, the famous health leader of New York City, remarked that within certain biologic limits a community can determine its own death rate. What he meant was that a community, by organizing its resources, can really reduce its own death rate. At the present time, with knowledge about the significance of health habits to health, we can paraphrase Biggs by remarking—within certain biologic limits every individual can determine his own risk of dying. That idea is beginning to grow nationally. We should be giving attention to it in graduate education for public health.

Parallel with these new endeavors of the federal government, the major private foundations of our country that are interested in health affairs have been reexamining their programs. Some new ideas coupled with new funds are becoming available. For example, the Clinical Scholars Program of the Johnson Foundation, now operative in a handful of health science centers around the country, is endeavoring to develop a new kind of clinical scholar: one who will be devoting himself not only to clinical medicine or to research in clinical medicine, but also to community application

of the best of medicine. A number of these programs incorporate a substantial measure of training for public health.

Thus, some new resources for support of professional education for public health are emerging in both the private and the public sectors. While they may not be large in dollars at the moment, they may be extremely important in what they portend for the future.

Regional Resources and Alliances

In addition to looking to the national scene, public and private, I would call attention to the importance of the regional scene's changing with the New Federalism. Regional cooperation offers considerable potential in the relationships between schools of public health and departments of preventive and community medicine in schools of medicine. One can envisage in the several regions of this country, perhaps the HEW regions, linking up the academic departments of medical schools responsible for teaching undergraduate and postgraduate students of medicine with the schools of public health. The purpose would be to enhance teaching research and community service in both preventive medicine and public health. This important alliance is an old one to many of us who have been involved in both faculties of schools of public health and the Association of Teachers of Preventive Medicine, but now there is a possibility at moving ahead significantly on a regional basis.

Earlier this week the Association of Schools of Public Health had an interesting meeting with State and Local Health Officers. One or two of the health officers remarked that they hadn't had much recent contact with the schools of public health from which they graduated, or with schools of public health in or near the health jurisdictions for which they were now responsible. As we discussed the matter together we found, as Dr. Stallones suggested, that reality may be better than the image. There is a fair amount of collaboration between schools of public health and the practice of public health in state and local health departments, but it is an aspect of our work that can be improved. Here again is not a new but a renewed alliance that the schools of public health must

cultivate in the interest of advancing graduate education for public health.

Further, in this regional consideration should be mentioned the increasingly sophisticated groups of professionals and consumers who are interested in the cost and quality of medical care and what it is doing for health. The important question is not just how much it costs and how many days of hospital care are utilized in different systems, but what the medical care system is doing for health. Both professional and consumer groups are focusing on that truly significant question of medical care and are turning to schools of public health on a regional basis for assistance in trying to answer it.

Local Resources and Alliances

Coming to the local level, many professional schools on campuses where there are schools of public health are showing increasing interest in how they can relate to public health. These other professional schools want to ascertain what their faculty, students, and curriculum might be able to contribute to the solution of health problems. This interest might seem to have a somewhat narrow or parochial origin—for example, getting funds for program support; but there is a more profound interpretation than that. We must recognize that not only schools of medicine, dentistry, and nursing, but also schools of management, planning, and engineering in the physical sciences, and departments of social and behavioral sciences really do have a great deal to contribute to public health. That is why schools of public health on many campuses are now systematically cultivating new relationships with other professional schools; not just joint appointments of faculty that look nice in bulletins and for accreditation visits, but relationships that are seriously devoted to substantial programs.

Conclusion

We can look for a considerable growth of alliances at the three levels: locally on the campuses; regionally with other schools, with the practice of public health, and with other academic elements

in the region, particularly departments of preventive and community medicine; and nationally. These new alliances will carry the schools to the next higher level of function as they move to meet the public health challenges of both today and tomorrow.

It is fair to say that during the last six or eight months those of us who have been responsible for administration in schools of public health have come through a period of shock. It has literally been that for every school of public health. Now we are beginning to sense, in recent weeks and here at this meeting, that the outcome will depend not so much on what has happened in the past and what others have done to us, but rather on how we respond in developing new resources and new alliances.

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