As President of the American Public Health Association, I wish to spend a very few minutes discussing the American Public Health Association. Many of you are active in APHA and have detailed knowledge concerning APHA. But for those who do not have such knowledge, I should provide a short overview.

The American Public Health Association was organized 109 years ago, and now enjoys a membership of some 52,000 national and affiliate members. APHA has had and continues to have a significant impact on health standards, policy, and legislation in the United States -- and Worldwide through the activities of our International Health Division. APHA publishes 1) the prestigious American Journal of Public Health; 2) The Nation's Health (a monthly newspaper reporting on current health legislation and policy issues); and 3) The Washington Newsletter, which provides the latest summary of health-related legislation and activities direct from the Nation's Capitol and federal agencies.

We have 25 different sections which run the gamut of all public health concerns and provide forums for diverse interests and discussions. APHA publishes a variety of books, such as "Control of Communicable Disease in Man", "Standards for Health Services in Correctional Institutions", "Standard Methods", and many others.

The purpose of the APHA is to protect and promote personal and environmental

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health, and this is the common goal and thread for the affiliates and the APHA.

At this time, I would like to take the liberty of reading a statement I made summarizing our Mid-Year Leadership Conference in Washington last June:

"During this Conference, we have learned that there is not a single crisis involving health policy, but a variety of major issues and crises involving not only scores of individual personal and environmental health programs, but an attempt to destroy the very structure and thrust of the personal and environmental health systems in the nation, with little understanding or care as to the effects of such actions.

"We have learned that public health personnel must become more active, assertive, and political in order to serve the health needs of our citizens.

"We now know that the battle for enhanced health status and environmental quality will be lost unless our 52,000 national and affiliate members are heard by their Senators and Representatives.

"We have been admonished that we must be constantly and increasingly vigilant, active, and understand the issues and the alternatives.

"We have been assured that we cannot wait for the other person to take action and speak for us. We must act individually and collectively, and NOW.

"We now know that we must be pro-active instead of re-active.

"I hope we have learned that we not only can, but must fight 'City Hall'... in this instance the Reagan Administration's anti-health and anti-environment measures.

"Our speakers have advised us that the Reagan Administration has no health plan, and only a poorly conceived economic plan resulting in a move to radically revise the role of the federal government and even the Constitution as they pertain to personal and environmental health.
"We have discussed public opinion polls indicating that the Reagan Administration received no mandate to destroy our health programs and status, or to reduce environmental protection measures.

"We have observed that defense spending and de-regulation of big industry are being supported to the detriment of our citizens' health and the quality of our environment.

"Further discussion has made it clear that the Block Grants are only a first step in the abdication of federal support for public health, and that Block Grant proposals would result in a 50% decrease in program capability during the first year alone.

"We are again informed that energy costs over which we have had little control have been the main cause of inflation, rather than government expenditures being the primary issue.

"We are justifiably irate that health and environmental programs and policies which have been carefully and responsibly developed over a period of many years are being attacked by the Administration with little regard for the human or environmental damages.

"We have been warned that the Administration will attempt to gut the Clean Air Act, the Safe Drinking Water Act, the Occupational Safety and Health Act, the Hazardous Waste Program, and others, if it is successful in destroying key provisions of the Clean Air Act.

"We have heard that the Reagan approach to health issues will tilt emphasis toward acute care while de-emphasizing more cost-effective primary care and prevention.

"We discussed the paradoxical situation wherein the Reagan Administration cast the sole dissenting vote against a code to recommend against the use of baby formula in developing countries under the guise of free trade shortly after pressuring the Japanese to curtail shipments of automobiles into the
United States. And Regan's moves to outlaw abortion and save the unborn seem unreal while he allows millions of the living to die from contaminated and unrefrigerated baby formula in developing countries.

"We have been advised that polls indicate that what the Moral Majority wants is not what the American public wants, and that we must not allow the Moral Majority to determine our policies or violate the constitutional rights of any group or individual.

"We have been reminded that the election of Reagan was more a rejection of Carter than an endorsement of Reagan's policies.

"We must remember that personal and environmental health measures need grass roots support not only by concerned individuals, but by every APHA Affiliate and by coalitions with other groups having a social or environmental conscience."

Today, it is my privilege to visit with you regarding a number of current and important issues in public health. I would first like to spend some time discussing disease prevention and health promotion.

Many of us old-time public healthers have never lost sight of the need for prevention, the value of prevention, and the cost-benefit desirability of prevention. We have watched with frustration and dismay while staggering billions have been poured into the sickness treatment system of our communities, states, and nation, with unsatisfactory (though expensive) attendant impact on the health status of our citizens. It was erroneously concluded that treating health problems was alone sufficient to improve the health status of our citizens.

During the last ten to twenty years, sickness treatment costs have escalated and skyrocketed to the end that such costs have become a serious economic problem which has become a priority issue for our health care providers, our political leaders, health care officials, and our health planning groups. They have realized that we must build a conscience for disease prevention,
health promotion, and environmental quality. They have been advised that we are going to be spending increasing piles of sickness treatment dollars with little overall impact on health status unless we improve our prevention efforts. They are increasingly recognizing that any national health insurance program would be doomed to failure and spiralling costs without more effective disease prevention and health promotion measures as a pre-requisite. National Health Insurance without such measures will be another expensive experiment in the matter of misplaced priorities and improper timing. Citizens are finally recognizing that we must stop expecting medicine to bail us out from the consequences of our own foolishness, and that we must stop waiting for tragedy before taking action. Health and Human Services Secretary Richard Schweiker has stated that "He'd like to be known as the person who put 'preventive health care and preventive medicine' at the top of the federal health agenda". He also emphasizes better health education.

There are scores of governmental, voluntary, business, and professional groups which play a key role in disease prevention programs. These include programs administered through federal, state, and local health agencies, colleges and universities, schools, county agents, home extension specialists, professional societies, voluntary groups, and businesses, all of which are essential in the struggle for quality prevention programs. I am sure you are proud of the preventive services delivered through the various agencies in your area, such as immunizations, communicable disease control, venereal disease control, cancer screening, hypertension screening, diabetes screening, maternal and child health, family planning, alcoholism prevention, mental health, substance abuse prevention, water pollution control, safe drinking water programs, air pollution control, radiation protection, occupational safety and health, insect and rodent control, food sanitation, solid waste management, and hazardous waste control.
Despite a long-standing commitment to prevention, we have frequently witnessed more prevention rhetoric than substance. Prevention continues to be difficult to sell to legislatures and local governing bodies, whereas treatment and rehabilitation programs usually continue to be better funded and more acceptable to those entrusted with authorizing and budgeting public funds. Even when a health agency goes before a budgetary body with "prevention" as the number one priority, the number one request is frequently by-passed in favor of lower priorities such as treatment and rehabilitation. Prevention programs, unlike treatment and rehabilitation programs, have lacked a constituency. When considering funding for any one of a number of treatment or rehabilitation programs, the legislative hearing room may be filled with assertive constituents wearing their appropriate hats, banners, or badges. Not so with prevention. Prevention has always been a rocky road and this continues to be the case, because in the eyes of many people it provides no immediate gratification or feed-back. It does require the ability to look to the future. Prevention, thus far, lacks the glamour commonly associated with physicians and hospitals, diagnosis and treatment, and therefore does not compete well with sickness treatment and crisis medicine.

While most of us have some reason to be proud of the various prevention programs in our states, I do not share this feeling when it comes to health promotion. By health promotion, I mean the effective use of health education in ways that move people to action. Many health personnel have not had a good handle on health education and health promotion, and to date have not really packaged them properly so the services will be delivered in an effective, coordinated, and visible fashion. We have traditionally and historically been expert at telling people what to do, but frequently have not understood the desirability of working with people to determine what they want so that we might correlate health goals with other personal aspirations and desires
of our citizens.

Realistically, we must admit that most health policy, at this time remains focused on sickness treatment and rehabilitation rather than prevention and promotion, and this continues to be evidenced by the lopsided funding allocations for treatment and rehabilitation. Like beauty, health promotion lies in the eyes of the beholder rather than in the funding allocated.

Despite the problems with funding and policy acceptance, we can be proud of reduction in communicable disease, smallpox eradication, a high rate of immunization of school children against seven diseases, a decline in infant mortality, a decline in cardiovascular mortality, and a definite trend toward decision-makers realizing that an investment in health promotion and disease prevention makes good sense. We have seen a decline from 51% to 37% in adult smokers since the first Surgeon General's Report; we have a tremendous interest in healthful diet; exercise and physical fitness are much better accepted; we have an improved knowledge of stress as a health factor; and better program relationships between mental health and other aspects of public health. And, in general, we have a great deal of public and social momentum toward acceptance and utilization of disease prevention and health promotion.

Generally, we have not fully used health education as a tool to better deliver health promotion services in an effective manner. Running and jogging, for example, are usually perceived as being activities engaged in by the middle and upper-class citizens, and may not be socially desirable at all for many citizens in other socio-economic categories. Good involvement with health education would help us determine what type of physical activities might be more desirable for people in various rungs of the socio-economic ladder. People in the slums of urban areas, for example, may place a great deal of emphasis on such physical activities as weight-lifting and body-building, but are not at all interested in jogging in the beautiful and inspirational environment
of an urban slum.

But, back to prevention -- while the toxic effects of tobacco and alcohol are well-documented, a little plague or cadmium in the environment frequently creates havoc with health personnel and the news media. I cringe with frustration when I note the effort health personnel devote to some minor public health issues, and the space and attention afforded such issues by news media; and always wonder how many humans suffered or died prematurely that same day from the toxic effects of tobacco or alcohol. Or of equal importance, how many citizens are not enjoying positive health and well-being due to the insidious creeping effects of tobacco? We need to re-define the term "crisis" to include conditions which allow a crisis to exist, such as the growing of tobacco, the sale of tobacco, the promotion of tobacco, and the utilization of tobacco.

It is essential to understand the large stakes that some industries have in opposing widespread behavior change with respect to their products. For example, an employee publication of the J.R. Reynolds Tobacco Company recently included the following: "If the current efforts of anti-smoking groups to restrict smoking in public places were to result in no-smoking laws which caused every smoker to smoke one less cigaret a day, J.R. Reynolds Tobacco would stand to lose $92 million in sales every year." Understandably, the Chairman of the company added, "But we have no intention of standing idly by while this happens." As if to prove its point, Reynolds spent $40 million in one six-month period in 1977 to launch a single cigaret. The industry's highly successful advertising and lobbying efforts are legendary.

Not too long ago, Russell Baker of the New York Times, wrote he had no objection to people who did not smoke just so they did not do it around him. Now, non-smoking has become more fashionable than smoking.

By and large, providing people with health information does not change health attitudes and health behavior, and it is more important to learn what
people want than for us to tell them what they need. Public health information does create an awareness, but not necessarily behavior change. People are more apt to respond to public health information if it does not involve a change in lifestyle; for example, the administration of polio vaccine. People are not so apt to respond to something they fear and do not wish to discuss, such as cancer.

We must constantly elicit the view of what people themselves want. Only in this way will the social pressures be developed for changing health behavior. We professionals bring an expertise, but so do consumers, and we need consumers in alliance with us.

Our people are by nature suspicious of coercion, and resist both restrictions imposed on them for their own good, and exhortations to shape up in their personal lifestyles. Yet again and again, our citizens have responded to leadership and reason when a convincing case has been made to them in terms they can weigh and evaluate.

Even the Federal Alcohol, Drug Abuse, and Mental Health Administration has finally recognized the importance and necessity of prevention, and has stated that the major focus for policy and program development will be on primary prevention; the greatest long-term potential for significant changes in health status appears to lie with primary prevention efforts. That is a far step from the funding concepts used in the past which have been totally oriented to treatment and rehabilitation rather than prevention and promotion.

Surveys continue to indicate that more than 90% of our citizens agree that if we Americans lived healthier lives, ate more nutritious food, ceased smoking, decreased consumption of alcohol, maintained proper weight, and exercised regularly, it would do more to improve our health than anything doctors and medicine could do for us. There is widespread recognition among the public of the need for a major shift of emphasis toward more and better disease
prevention and health promotion efforts. However, many still have unhealthy aspects of their lifestyles. Knowledge alone is not enough to change health habits. For example, the vast majority of smokers know that smoking increases their chances of getting cancer or one of many other adverse health conditions... and yet they still smoke. But knowledge is a necessary first step and is almost always an essential component of change.

More than ever before, examination of the causes of poor health and disability and the means available for improving health status must focus on health education as the best means of achieving public health goals. The next improvements in health status must come from changes in lifestyles and from improved control of health hazards in the environment.

It is probable that we can do more to enhance health status and quality of life through more effective community health education than through some of our other time-honored and better accepted and funded activities. However, issues of federal, state, and local mandates and expectations, and constituency pressures preclude complete managerial flexibility and effectiveness in developing programs best designed to solve or ameliorate priority health problems.

Health education has repeatedly been more difficult to sell to budget officials and legislators than activities defined in terms of clinics, hospital beds, patients, immunizations, inspections, or numbers of analyses.

Prevention and promotion are "issues whose time have come", in terms of rhetoric -- while funding continues to be channelled to treatment and care programs which have the citizen constituency who regularly appear at administrative and legislative budget hearings. We do not have an organized prevention and promotion constituency despite the acknowledged fact that prevention and promotion are cheaper and more effective than care -- and enhance the quality and enjoyment of life.
If states and the Nation are to have a commitment to prevention and promotion, health education must be the mainstay -- the backbone of a concerted effort to improve the health status of our citizens. We must have a commitment to preventing damage to the human machine in balance with efforts to repair the human machine after it is wrecked. And again, I would emphasize the importance of enjoying positive health through known, documented changes in lifestyle related to smoking cessation, exercise, nutrition, drinking, weight and obesity, mental health, and environmental health. Such changes in lifestyle would directly affect the leading causes of death and disability among our citizens, such as heart disease, cancer, and accidents. Health education is also a basic strategy when dealing with hypertension, family planning, maternal and infant health, immunizations, venereal disease, control of toxic chemicals and hazardous waste, occupational health and safety, dental health, communicable disease control, mental health, alcoholism, and drug abuse.

We need an extension of disease prevention and health promotion services to the un-served and under-served, and we must target our efforts in more effective ways even though this will mean a re-allocation of personnel and resources.

Within the past 10 to 15 years, Congress and state and local governing bodies have enacted numerous laws designed to protect human health by managing the environment. Many of these laws have gone even further and have dealt with such related issues as atmospheric visibility, water clarity, property damage, and plant and animal life. All these laws were enacted in response to the evident public clamor for a healthy environment. The struggle for a quality environment takes place in many arenas, and after the legislative arena, the confrontations have shifted to the regulation promulgation arena where those interests which failed to win legislative battles are looking
for another opportunity to weaken or undermine environmental health programs.

Some of these pollution interests would have us choose a course which not only sacrifices the public's right to good health, but has the ultimate effect of increasing medical, hospital, and insurance bills. Now, some of the official inflation fighters have targeted environmental and occupational measures for their criticism while admitting that they really have no cost data on environmental and occupational diseases. Since these economic experts don't know the costs, they won't consider them in a cost-benefit equation. And still worse, they seem to reject any responsibility for gathering the data on the effects of environmental disease in terms of disability, inefficiency, morale, comfort, quality of life, life-span, absenteeism, insurance rates, Medicaid and Medicare budgets, and other health care costs. It does seem reasonable, however, that we should be able to save some portion of the annual more-than-$100 billion cancer, heart, and lung disease bill by controlling the environmental causes of some of these diseases.

We have a long way to go in sharpening and utilizing the tools of environmental epidemiology to better identify the health effects of environmental chemicals and stresses.

Our political leaders largely ignore the issue of population stabilization, which (and while frequently an emotional issue) is an absolute necessity for the human animal to thrive in balance with the resources of his environment -- including energy supplies. The human species, either through rational behavior or environmental limitation, must and will be limited. The plight of our energy addicted and starved society may well portray a system that has filled its "ecological niche". The social, political, and environmental consequences of over-population are evident daily.

Recent public opinion surveys have continued to indicate that Americans favor environmental protection even at a price.
The majority of Americans say they favor efforts to control pollution and protect endangered species despite concerns over the economy and energy supply, according to a 1980 survey commissioned by the President's Council on Environmental Quality and three other governmental agencies. The poll found that 55% of those surveyed said their views were sympathetic toward the environmental movement, while 7% were active in it. 83% said the government should screen new chemicals for safety before they are allowed to go on the market, even if doing so might keep potentially useful chemicals away from the public. Solar energy was chosen by 61% of the population as the energy source on which the Nation should plan for the future. And the poll also indicated that the Nation should not plan for any new nuclear plants, but continue using those in operation or currently under construction. 75% said that an endangered species must be protected even at the expense of commercial activities. 61% of those polled felt that we should concentrate the most on development of solar energy, while only 23% thought we should concentrate the most on nuclear energy. Further, most of those polled thought solar energy would take less effort to develop than nuclear energy.

There is no doubt that environmental measures contribute to inflation, but only moderately. A 1981 study prepared for EPA by Data Resources Inc., (DRI), of Cambridge, Massachusetts, estimates that spending by major industries and state and local governments to meet federal pollution control requirements will add nearly 0.6 percent per year to the Consumer Price Index between 1981 and 1987, but that nationwide unemployment rates will be 0.3 percent less in the 1970-87 period as a result of an estimated 524,000 new jobs created by the same pollution control requirements.

More recently, we have learned that a large majority of Americans support the current provisions of the Clean Air and Clean Water Acts, and many favor making the laws even stricter, according to a 1981 survey by the Lou Harris
organization.

By 86% to 12%, those surveyed oppose making the Air Act less strict, and by 93% to 4% they oppose easing up on environmental rules governing water pollution, the survey found.

About 12% want to make the Air Act less strict; 48% want to keep it as it is, and 38% want to make it stricter.

The Harris Survey found that 52% of Americans want to make the Water Act stricter; 41% want it to remain the same, and only 4% want to make it less strict.

Whatever public backlash has developed against environmental measures would appear to be aimed more toward questionable regulatory methods than against the basic statutes and the goal of a healthy environment. This behooves regulation promulgating authorities to utilize rational and acceptable methods and strictly follow the statutory intent. But those protesting regulations must be reminded that regulations are mandated not by bureaucrats, but by congressmen and legislators elected by the citizenry.

U.S. Senator Gary Hart, of Colorado, recently noted that, "Public support of air quality is stronger than ever before, but public frustration with government regulation is also stronger. A major challenge before us is to satisfy both of these popular demands: cleaner air and less burdensome regulations." Perhaps greater utilization of economic incentives such as a "pollution tax" should be effected. This is a methodology which has not been well-utilized. However, limited experience in the Delaware River Basin has indicated that taxes could reduce water pollution as much as current regulations ... but at only half the cost.

It has become increasingly important, but perhaps not more common, for environmental health agencies to have their own economists to study cost-benefits of existing and proposed requirements and to counter as necessary
some of the ridiculous economic claims of those interests opposed to environmental controls. A November, 1979 Abstract of a paper entitled, "Putting Environmental Economics in Perspective: Case Study of Four Corners Power Plant, New Mexico," by John R. Bartlit, D.Ch.E., published in the American Journal of Public Health, states that, "Environmental control costs can be made to appear much larger in impact than they actually are by placing costs in misleading contexts or failing to provide perspective. It is essential for continued public support of environmental health programs that this practice be countered by more meaningful presentations of economic data. As an example, analytic methods appropriate to the case of a large coal-fired power plant in northwestern New Mexico are developed and discussed. Pollution control expenditures at the Four Corners Power Plant were presented as costing $82 million annually. Although this figure may be the correct one, data were collected and analyzed to show that this cost represented an increase of only 5 to 60 cents on a $100 electricity bill for the consumer of electricity."

Many of us remember the "olden" days when the vast majority of environmental health programs were organized within the framework of the then traditional State Public Health Departments. But with emphasis on consumer protection, comprehensive programming, organizational visibility, importance of citizen input and participation, and effective regulatory actions, the organizational picture has changed radically within the past decade. Public and political clamor, and concern over the rapidly deteriorating environment in the late 1960s caused a widespread re-evaluation of environmental problems, program goals, program support, program effectiveness, as well as organizational settings. Programs were shifted to new and/or different agencies for a variety of reasons -- some valid, and some questionable. Eager citizen environmentalists and citizen action groups sometimes confused change with progress. Public health and environmental health officials generally exhibited a high degree of territorial
defense and relatively low titer of organizational and program management knowledge. Powerful polluter lobbyists delighted in the opportunity to retard and confuse environmental health measures through repeated reorganizations and by placing health personnel and programs in positions of greater "political responsiveness."

Regardless of the organizational placement of environmental health, the goal should be to insure an environment that will confer optimal health and safety on this and future generations. The mission should be one of citizen and environmental protection rather than environmental utilization and development. Some environmental health agencies have not fully developed the concept of mission and have been ready prey for those polluters and others they are charged with regulating. This has sometimes resulted in the environmental health agencies protecting or promoting the interests of those they are charged with regulating.

It is increasingly important to realize that the concern of environmentalists with wildlife and the natural environment is a sound manifestation of interest in the entire natural system of which the human animal is a part, and the environmental effects on wildlife serve an "early warning" or "preview of coming attractions" in accordance with the known and proven ecological maxim that "everything is connected to everything else." And citizens are learning that sound environmental health measures must be for today and tomorrow -- not just tomorrow.

I cannot conscientiously address the matter of environmental problem priorities without noting the impact of other societal issues on environmental problems. Over-population and the resulting consumption and/or destruction of non-renewable resources is the single highest priority affecting the environment. Population stabilization is the only real preventive endeavor, as curative programs to control the resulting secondary problems of environmental degradation,
energy shortages, transportation, land-use, congestion, crime, and famine have not and will not be effective without resolving the basic issue of over-population.

Health professionals should support specific national and global actions and agreements to stabilize human population levels through such mechanisms as education, racial justice, sexual equality, technology sharing, birth control, re-orientation of social values and attitudes, demographic research and planning, and economic and fiscal policies and incentives.

Energy for homes, industries, and transportation from non-polluting, renewable energy sources is another major issue having an impact on environmental health problems. For a number of reasons including industry monopolies, union agreements, and government conflicts-of-interest, the Nation has not made even a good token commitment to solar resources.

Underlying the previously-mentioned issues are ignorance and poverty which must be addressed and solved for there to be substantial, permanent, long-range progress toward our goal of "an environment that will confer optimal health and safety on this and future generations," or FOR PEOPLE TO DIE YOUNG AS LATE IN LIFE AS POSSIBLE.

With regard to the environment and the economy, let us not be misled into a process of "versus" or "either-or." A quality environment and healthy economy are not contradictory expectations, and, in fact, are mutually inter-dependent. We can't have an economy without an environment. "Ecology" and "economy" are both derivatives of the Greek word "ekos" (oikos) which means house. An economist was a keeper of the house, and an ecologist is a keeper of the big house in which we all live -- or our environment -- the place in which we are all going to spend the rest of our lives.

It is a matter of serious concern that the human animal sometimes seems more willing to suffer the health, social, and economic consequences of disease
and pollution than to pay for environmental health for this and future generations. Perhaps the human animal can slightly adapt to some degree of environmental degradation, but it is indeed alarming that the human animal might attempt to merely survive through adaptation rather than thrive through environmental quality.

Escalating health care costs are prompting many businesses and industries to seriously consider company-sponsored programs of disease prevention and health promotion as measures to reduce those costs. Industries and unions are attempting to contain such costs and improve employee health and well-being by instituting programs of disease prevention and health promotion to compliment the traditional occupational health programs that are directed toward control of health and safety hazards in the work place. These new programs are focusing on those health issues over which the individual has some degree of control, such as those relating to cardiovascular disease, cancer, stroke, mental health-related problems, and accidents. To date, most of these programs have not been scrutinized through planned evaluation measures, but more companies are beginning to conduct such evaluations.

All this has additionally created a new industry for the creation and sale of employee fitness programs, several of which are based here in the Minnesota area.

There are a number of points the businesses and industries are considering which should have the effect of enhancing the health, comfort, morale, and productivity of employees as well as keeping down health care costs and improving the profits of the businesses. These include:

1) providing a healthy working environment so as to enhance employee health, reduce absenteeism, increase productivity, reduce medical and insurance costs, and increase profits;
2) Making facilities available for employees to exercise, and then promoting the idea;

3) Considering providing health spa memberships for selected employees;

4) Supporting health promotion classes which include such subjects as smoking cessation, stress control, weight control, proper nutrition, and hypertension control;

5) Tying in with a Health Maintenance Organization that offers prevention services;

6) Designating non-smoking areas in the work place, lounges and cafeterias, so that all employees are not forced to breathe second-hand smoke;

7) Requesting free occupational health and consultation services from the official OSHA Agency;

8) Contracting for risk assessment and reduction services for employees;

9) Placing fruits and juices in snack bars and vending machines as an alternative to the junk foods commonly available;

10) Sponsoring "self-health care" discussion groups to teach employees more about healthful lifestyles and personal health care;

11) Sponsoring "troubled employee" programs to provide confidential counselling for employees with alcohol, drug, or stress problems;

12) Promoting "pools" designed to promotion of weight reduction and smoking cessation;

13) Offering screening services for early diagnosis and treatment of such problems as hypertension, heart disease, cancer, arthritis, and diabetes.

We must have a realistic, accepted and working health policy based on health and wellness. All this will imply major changes in public health where the priorities will be centered around life-styles and require a multitude of decisions by all of our citizens daily. A rational public health future is possible and whether it occurs or not depends upon all of us. One of our
most compelling messages is not that our citizens can merely live longer, but enjoy life more and feel younger. It is up to us to see that citizens see health promotion as a promise and important to the enjoyment of life. The obstacles remain numerous, varied, and formidable, but we must remember that public health is purchasable, and that within natural limitations any community may determine its own health status and environmental quality. Let's not allow disease prevention, health promotion, and environmental quality be ignored and left half way between leprosy and the quarantine station. Let's make certain that prevention and promotion programs are effectively supported, organized, and administered.

It would be inappropriate to interpret the recent election as a mandate to repeal certain of our hard-won environmental and personal health measures and programs. National surveys have continued to indicate that the majority of our citizens still favor effective pollution control measures. 1980 election-day results throughout the nation indicated voter approval of local bond issues, most of which were for environmental protection facilities relating to water pollution control and waste disposal. No turn to the right or turning back the clock here!

The Reagan Administration has now been in power for some nine (9) months, and we now have a good idea regarding their feelings about health funding and policies. In a nutshell, we in the APHA believe that it can only be labelled as "disastrous." His recommendations have ranged from cutting family planning, community health centers, cuts in EPA and OSHA, the National Health Service Corps, through phasing out Health Planning, support for PSROs, Health Maintenance Organizations, and on to a 20% reduction in the Hazardous Waste Super Fund, a 27% reduction in surface mining inspections, slashes in the wastewater treatment grant program, attacks on the Clean Air Act, to de-funding the very incubators of public health professionals — our schools...
of public health. It is ironic and interesting to note that President Reagan would not have survived the recent assassination attempt had it not been for a medical system at George Washington University in Washington, D.C., built to a large extent with federal funds. The Emergency Medical Systems Program which helped organize George Washington's "Level 1 Trauma Center," would be ended, and similar programs in other states might be discontinued with limited federal block grant funds, under Reagan's cost-cutting program.

Block Grants are not a new concept. The first block grant for health programs became known as 314(d). The funding was developed back in the 1960s in response to the hue and cry of state health officials that they could handle the funds better and place priorities on health problems more effectively at the state level than could their counterpart bureaucrats on the Potomac. Grants under 314(d) "blocked" a number of previous categorical funds and allowed a considerable degree of flexibility in their utilization. In practice, most states changed their priorities little from what had previously been determined by the Feds for categorical funding. But an interesting result ensued. Soon, the state health departments became the only constituency for 314(d) funding with the predictable results that such funding has gradually decreased, has been the object of budget recisions, and is now only a shadow of its former self. What was envisioned as a giant became a pygmy.

Many of the existing categorical programs were developed because states either could not or would not do it themselves. This has been true of such programs as Family Planning, Migrant Health, Community Health Centers, and others.

Originally, the Reagan Administration proposed grouping some 26 categorical programs into two health block grants, and suggested that the proposed 25% reduction really would not be all that serious because much of it would be re-gained by eliminating the federal bureaucracy administering the categorical funds.
It is important to emphasize that the figures developed during the reconciliation process are for authorizations, not appropriations; and that the appropriations are now being developed. It is probable that the appropriations will be lower than the authorizations.

It is ridiculous to state that we will get more health services for less simply by dumping reduced funding on the states. Obviously, we will get less for less. The prevention area, which offers the best hope for improved health status and which has the best cost-benefit ratio, will be hit hardest, simply because it does not have an organized constituency.

A little simple arithmetic indicates that the actual cuts in services delivered to people will be significantly greater than the 25% to which the Administration admits. The 25% reduction leaves 75%. However, the proposed funding is based on current levels of categorical funding and does not include any increases for inflation. Additionally, each state government will have to retain an appropriate sum to develop its own controls to responsibly handle the funds and be accountable for their proper and legal utilization. After subtracting these overhead costs and the program reduction caused by inflation, we will have something like 60% of the current level.

By definition, block grants include 100% funding. What the President originally proposed were really not block grants due to the decreased funding. It is obvious now that block grants are an entering wedge in a scheme to transfer program responsibilities to the states without the transfer of revenue resources. This transfer has aptly been termed "shifting the shaft", with the states handing out the bad news.

And now let's get back to the matter of the lack of a constituency. If Mental Health, or Drug Abuse, or Alcoholism, or CCS, or Health Education, or Migrant Health constituencies were to find the need for increased federal funding and convince Congress of the need, there would not be the slightest
assurance that any increase would be utilized in the interests of that particular constituency at the local level. Therefore, I foresee a gradual erosion of funding for the four block grants just as we witnessed for 314(d).

Each Governor and Legislature will face increasing pressure and witness increasing competition for available state health dollars.

We need the continuation of a balanced, coordinated effort between the federal government and state and local governments to best serve the interests of all of our citizens.

The President has also appointed or nominated incredibly unqualified personnel for key positions, such as the Administrator of the Environmental Protection Agency, the Assistant Secretary for Occupational Health and Safety, the Secretary of the Interior, and the Surgeon General. We have gone on record as opposing most of these and have been particularly active in opposing the appointment of a pediatric surgeon with no previous interest or experience in the field of public health as Surgeon General.

From the Arizona Public Health Ness, "Prevention", by Joseph Melin:

'Twas a dangerous cliff, as they freely confessed,

Though to walk near its crest was so pleasant;

But over its terrible edge there had slipped

A Duke and full many a peasant.

So the people said something would have to be done

But their projects did not all tally,

Some said, "Put a fence round the edge of the cliff."

Some, "An ambulance down in the valley."
But the cry for the ambulance carried the day,
    and it spread through the neighboring city;
A fence may be useful or not, it is true,
    But each heart became brim full of pity
For those who slipped over the dangerous cliff,
    And dwellers in highway and alley
Gave pounds or gave pence, not to put up a fence,
    But an ambulance down in the valley.

Then an old sage remarked, "It's a marvel to me
    That people give far more attention
To repairing results than to stopping the cause,
    When they'd all better aim at prevention."
"Let us stop at it source all this mischief," cried he.
    "Come neighbors and friends; let us rally.
If the cliff we will fence we might almost dispense
    With the ambulance down in the valley."

"Oh, he's a fanatic," the other rejoined;
    "Dispense with the ambulance? Never!
He'd dispense with all charities, too, if he could.
    No, no, we'll support them forever!
Aren't we picking up folks just as fast as they fall?
    And shall this man dictate to us? Shall he?
Why should people of sense stop to put up a fence,
    While the ambulance works in the valley?"
But a sensible few, who are practical too,
    Will not bear with such nonsense much longer;
They believe that prevention is better than cure,
    And their party will soon be the stronger.
Encourage them, then, with your purse, voice, and pen,
    And while other philanthropists dally,
They will scorn all pretense and put up a stout fence
    On the cliff that hangs over the valley.

I hope that this Conference is a rewarding for you as the preparation has been for me.