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The Importance of Community as an Empowered Partner for Health and Wellbeing

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I would like to talk to you today about the importance of the community in our efforts to prevent disease and promote health. Believe it or not, this is a subversive topic in many parts of the world. The normal approach to this issue is for health experts to do research to identify unhealthy behaviours and then to inform the public about our discoveries. Eat less meat! Lose weight! Don't smoke! And so on. While some of these orders from on high work some of the time, overwhelmingly they have failed. I can speak about this with authority because I have failed perhaps more often than many. I am an expert on failure. I have, finally, over the years, come to see the most important reason for this failure: my failure to recognize the importance and power of involving the community in my work. Involving the community as an empowered partner. It is all well and good to say this. It is not so easy to do. Especially if you have been trained, as I have been, to be an arrogant, elitist, prima donna expert. Most of us in the health professions are experts, after all, and all we are trying to do is help people by sharing our expertise. And therein lies our problem.

Let me illustrate this issue by telling you about a smoking cessation project I directed in Richmond California. I came to this project with a dismal record of failure in helping people, one at a time, to quit smoking. I resolved, in the Richmond project, to take a different tack. The Richmond project was designed as a community project. There would be a block captain in every neighbourhood in Richmond; we would involve the business community, the schools and many community groups. The idea was to change the climate in Richmond with regard to smoking. To challenge the acceptance of smoking, the values and the attractiveness of smoking.

I wrote a brilliant 5-year research grant and sent it to the National Cancer Institute. It was a bold, and expensive 2,000, project and, for that reason, they sent a large site visit team to discuss it with us. At the end of the visit, they proclaimed the project as brilliant. They in fact later used my brilliant design as the basis for a nationwide study called COMMIT that was done in over 20 communities in the U.S.

Then we proceeded to implement the project for 5 years and we did a fabulous job. And at the end of the 5 years, we compared the results we achieved in smoking cessation with our two comparison communities – Oakland and San Francisco – and we found no difference in smoking quit rates.

It was only later, after I had stopped brooding over this disaster, that I finally began to see the issue. Richmond California is a very poor city. It has many unemployed people. Lots of crime. Lots of drug use. Very few health services. Lots of air pollution from nearby oil refineries. You get the picture. And I came to Richmond with my brilliant research plan and said: “Hey gang, let’s do a smoking cessation project!” Of all the problems faced by people in this community, I doubt that smoking would be very high on their priority list. But of course, I had never asked them about that and I probably would have persisted with my plan anyway. I was the expert after all.

But there is even worse news. Early in the project, a group of teenagers came to us and said they would like to make a rock video about smoking. They would write the music and words

but they wanted our help. What they wanted was to invite a famous rock star – I can't remember her name now - to spend one day on the project and they wanted a rock video photography person from Hollywood to come too. Would we help them arrange that? We hadn't budgeted for such an expense but we did it anyway. The rock star came in her limousine and the Hollywood guy showed them how to set up the scenes for filming, and so on.

The video they produced was shown at a at a large movie theater in the community. The students printed the tickets for this show, they did the advertisements, and they served as ushers. The show was sold out and it received a long, standing ovation from the audience. The video was subsequently shown in many places around the world and the community received royalty money for it.

Unfortunately, the video was not part of my brilliant research plan and we had no money to evaluate its benefits. So the one thing in the project that came from the community, and incidentally, the one thing that probably had the biggest impact, was not taken into consideration by the research team. So much for my brilliance.

Oh – and to add to my embarrassment- the nationwide COMMIT study has reported their results: the study failed to show a difference in smoking cessation rates between any of study and comparison communities.

Looking back at this experience, the question is: why was it so hard for us to accept the community as an empowered partner? It's not that difficult to understand the idea. It is not that difficult to understand the importance of the idea either. Why was I so blind? I think part of the answer is that we public health experts focus on our diseases and risk factors. We have in Public health things to learn about these diseases and we have messages to convey to people. The problem is that people have lives to lead. The meeting ground between our focus on diseases and their lives is not always smooth. Most often, there is a gap between the two and we do not do a very good job in recognizing and dealing with this gap. I am now going to discuss some rather delicate issues and I run the risk of offending many of you in this room. I apologize ahead of time. I will try to be gentle.

Let me begin by criticizing my own field: epidemiology. As I noted earlier, we in epidemiology spend a good deal of time attempting to identify disease risk factors. The rationale for this work is that if we can identify these risk factors and share that information with people, they will rush home and, in the interests of good health, change their behavior to lower their disease risk. There are three problems with this model. First, we have had a very difficult time identifying risk factors. Consider one of the diseases in which we have done a particularly good job: coronary heart disease. We all know the big risk factors for this disease: cigarette smoking, hypertension and high serum cholesterol. There are perhaps a dozen more risk factors such as physical inactivity, obesity, diabetes, and so on. Taking all of the risk factors we know about, together, we can explain about 45% of the coronary disease that occurs. So for the disease that is the number one cause of death in most country and for most countries in

the world and for which there has been an enormous amount of excellent research, more than half of the disease that occurs is not explained by that research.

That's problem number one. The second problem is that even when people know about their risk, it is very difficult for many people to change their behavior. I was involved many years ago in the classic demonstration of this problem. I am referring to the Multiple Risk Factor Intervention Trial – MRFIT. That study involved men in the top 10% risk category for developing coronary heart disease because of their hypertension, cigarette smoking and high serum cholesterol. Our plan was to get these men to lower their risk and demonstrate the lower disease rates that would eventuate.

Unfortunately, to do this, we were told by the statisticians that we would need to enroll 12,000 men in the study, 1/2 to work with us in the clinic and 1/2 to work with their own doctors as a control group. To find these 12,000 men, we had to screen almost 1/2 million men in 22 cities across the U.S. That was a lot of work and it was very expensive: about 1 million 1980 dollars - but we thought it would be worth it because we had done a good job in identifying these risk factors and because coronary heart disease was the largest cause of death in the country. By the way, if we had included women in the study, the study group would be increased to 30,000 with an attendant rise in budget. Women still do not have high enough rates of heart disease to qualify for studies that focus on the highest risk groups.

After the first screening of this very large group of men, we told some of them that it looked as if they were at high risk to develop CHD but that we needed to do a more thorough screening

to be sure. And we told them that if they were still at high risk after the second exam, they might be eligible to be invited to enter a new intervention program we were starting. Almost all of the men we invited did in fact come to the second screening. That second screening was overwhelmingly intense and detailed. It took 1 1/2 hours. During this exam they were mercilessly probed, punched, run, stuck, pulled and squeezed. After it was over, we told some men that they did seem eligible for the trial: they did seem to be at high risk and they did seem to be free of coronary heart disease at that time. We then told them that we needed them to come back to the clinic one more time for another 1 1/2 hour screening to be sure of their eligibility. We told them that if they were still eligible after the next screening, we would invite them to participate in the new heart disease intervention trial. But we warned them to think hard about whether they wanted to do this. We told them that if they were eligible, the first thing that would happen would be that they would be randomly assigned to work with us in the clinic or with their own doctor. If that wasn't agreeable, they should not get involved with the study.

If they were assigned to work with us in the clinic, we would ask them to change their diet, to take pills for their high blood pressure and to stop smoking. We would also ask them to come to the clinic very frequently at the beginning, oftentimes with their family, and that the Trial would go on for 6 years. They should not volunteer if they had any reservations. And then we gave them a big stack of questionnaires to fill out for next time. And we had a psychologist in every clinic who recommended that certain men be rejected because they did not seem to be good prospects for the long haul.

In the end, we selected a highly informed and highly motivated group of men. And we involved them in a superb intervention program. For example, we invited the men and their families to the Clinic to demonstrate low-fat cooking. We took them to the supermarket to show them how to read labels. We went to their homes to cook with them. And so on. We did the study about as well as it could be done.

And the Trial failed. After 6 years, there was no statistically significant difference in heart disease rates between the Special Care group and the control group. This was primarily because so few men in the Special Care group changed their behavior in comparison to men in the control group.

So, the first problem is that we epidemiologists have had a difficult time identifying disease risk factors but the second problem is that even when we are successful in doing this, it has been very difficult for people to change their behavior to lower their risk. The third problem, however, is the most challenging of all. Even if everyone at risk did change their behavior to lower their risk, new people would continue to enter the at risk population at an unaffected rate. This is because we rarely identify and intervene on those forces in the community that cause the problem in the first place.

This a major issue for those of us interested in improving the health of people. If one of our goals is to prevent disease and promote health, I don't think we can accomplish this job by an exclusive focus on individual diseases and risk factors. There is a lesson to be learned here by looking at the success we have had in preventing many infectious diseases. Some of that

success has been attributable, of course, to vaccines. But most of this success has been due to an improvement in the environment. This improvement came about because of the way in which diseases were classified. Those disease classifications were in terms of water-borne diseases, food-borne diseases, air-borne diseases and vector-borne diseases. These disease classifications are not of much value clinically – in the treatment of individual cases – but they are of great importance in telling where diseases are coming from and where we should direct our prevention efforts. Do we have a similar classification system for the noninfectious diseases of concern today?

If I sent a research grant proposal to the National Institutes of Health in the United States to study poverty diseases, to what disease specific institute would they refer my request? The National Heart? The National Cancer Institue? The National Arthritis Institute? Or what about a proposal to study nutritional deficiency diseases? Or racial discrimination diseases? The U.S. National Institutes of Health would not know what to do with such proposals. They would probably send it to the Institute that most closely approximated what I was getting at but that would do fundamental damage to the point of my request.

A few years ago, the Canadian government was considering the establishment of an NIH for Canada. Many of us warned them that if they patterned their NIH along the lines of our NIH, it would be a major setback for the cause of disease prevention. They did establish a Canadian Institute for Health Research. They did set up a whole series of Institutes focusing, as we do in the U.S., on heart disease and cancer and arthritis, but they also established institutes of Population Health, Gender, Aboriginal Health and so on. We in the U.S. have some institutes

of this kind: Aging is one, Child Development is another. Occupational health could be another but they tend to continue a focus on specific diseases that occur in an occupational context. The clinical, individually oriented tradition runs strong.

Suppose we were interested in developing a community-based framework for the prevention of disease and the promotion of health. What would it look like? The first job in developing such a framework would be to identify the most important population determinants of disease. What should we focus our attention on? Actually, this is not a very difficult task. We all, in fact, know the answer but, until very recently, we haven't wanted to talk about it or do anything about it. The most important social determinant of disease is social class. Social class has been an overwhelmingly important risk factor for disease since the beginning of recorded time and it is related to virtually every cause of disease that we know about. We all know this. But we have not known what to do about this observation. If revolution is the only useful intervention to remedy the ills of social class, it is not surprising that public health people have instead been more interested in working on the relationship between physical activity and diabetes.

For example, if you were willing to take on the issue of social class as an intervention focus, what would you intervene on? Money? Is poverty the main ingredient driving the social class-disease connection? Or is it education? Or perhaps inadequate nutrition? Or inaccessible and costly medical care? Or bad housing? Or bad jobs? Or a contaminated physical environment? Which of these is most important? The answer, of course, is that these factors are all important and they are all inextricably bound up together. It makes no sense to try to tease

them apart and pretend that one is more important than the other. So let's change the subject and study something else.

The breakthrough in all this came a few years ago when a former student of mine - and a former Australian who got his medical degree in Sydney - Dr. Michael Marmot, studied coronary heart disease in 10,000 British civil servants. He found, as you would expect, that workers at the bottom of the civil service hierarchy, workers who were guards and delivery people had heart disease rates 4 times higher than those civil service people at the very top of the hierarchy. As any self-respecting epidemiologist would be expected to do, he adjusted these data to take into account all of the heart disease risk factors we mentioned earlier plus about 50 others including blood clotting and number of cars owned. After adjusting the data for all these factors, the difference in heart disease rate between those at the top and those at the bottom was reduced to 3 1/2 times. Still an enormous difference. But one we would have expected.

The interesting part of the story is that he observed a gradient of disease from top to bottom of the civil service hierarchy. Those at the top had the lowest rates of disease but those one step below them, professionals and executives, doctors and lawyers, had heart disease rates twice as high as those at the very top. Now, we might be able to explain the high rates among those at the bottom in terms of poverty or poor education, or inadequate nutrition or poor housing, etc but that would not explain why doctors and lawyers had rates of disease twice as high as those at the very top. Doctors and lawyers are not poor. They do not have bad educations. Or poor medical care. Or poor housing. And yet they have disease rates twice as

high as those above them. Those above them are the directors of the civil service agencies. These are the people who wear black bowler hats and carry umbrellas. All of them have been educated at Oxford or Cambridge and all are knighted at the end of their careers. They rule the world.

Below the professionals and executives in the hierarchy, there is a step-wise gradient of increasing rates of disease. And this gradient persists even after account has been taken of over 50 risk factors that might otherwise explain this phenomenon. And, of course, all of these civil servants are covered by the British national medical care insurance program. When I was visiting Marmot in London, my first thought was that these data were a reflection of some bizarre phenomenon limited to the issue of coronary heart disease. It is not. The same pattern exists for every single disease in the civil service. My second thought was that it was a bizarre phenomenon associated with workers in the British civil service. It is not. This identical pattern has now been seen for virtually every disease in every industrial country in the world.

This is a major breakthrough in our thinking. Instead of shaking our heads at the complexity of social class as a determinant, perhaps there is something we can do about it. Marmot's observations do not mean that we can ignore those at the bottom. It just means that perhaps something else is going on that would explain the higher rates even near the top. This does not solve all of our problems but at least it gives us something to think about and to work on. Which is better than simple ignoring the issue. For his work, by the way, Marmot himself was knighted by the Queen of England. And the Nobel Prize Committee is rumored to be thinking

about him as well. Which would be a major breakthrough in itself because the Nobel Prize in Medicine is usually given for contributions in molecular biology, genetics, immunology, and the like.

Returning to the gradient: How can we explain it? It was easy to understand why those at the bottom might have high rates of disease but how does one explain the high rates among those near the top of the social class hierarchy? A lot of people are working on this question but my own hypothesis involves what I call "control of destiny" By this unfortunate phrase I mean the ability of people to deal with the forces that affect their lives. Even if they decide not to deal with them. I don't know if this is a worthwhile concept or not – I think it is – but if is not, we need some other idea like it. The point is this: If we are going to prevent disease, we need to intervene on those community forces that cause disease problems and social class is the obvious and most important such factor. Since social class is such a complicated concept, it would really be helpful to identify some ideas that are related to the social class gradient that are amenable to intervention. If control of destiny is an important issue, it is something we can develop interventions around. I will return to this idea later.

Allow me to summarize the argument so far: I have suggested that a major impediment to effective interventions is that we in public health have messages but that people have lives and that we need to do a better job of bridging the gap between these two. And I have argued that the reason we experts have such a difficult time in solving this problem is that we in public health focus on specific diseases and risk factors where we have clear expertise.

Then I suggested that the specific disease model approach has not gone well. We can't identify risk factors very well, we can't get people to change their behavior even when we do and, finally, even if they did change behavior, new people would keep coming into the at-risk population because we do not work on those community forces that cause the problem in the first place. My final point was that the most important social force was social class and that we might be able to figure out some approaches to dealing with it in a realistic way.

The reason that this is important is that if could move away from diseases and risk factors and begin to think about community and social forces, we could probably relate to the community in a more meaningful way. We would have a better chance of involving the community as an empowered partner.

Let me illustrate what I am getting at. Several years ago, I applied for a grant from the Centers for Disease Control in the U.S. to study 5th grade children in a low-income community near Berkeley. The CDC had invited grant applications that would focus on cigarette smoking and other drug use, violence, poor school performance, inappropriate sexual behavior, and so on. But when we wrote them, we said that we had decided not to study any of those things they card about. This is not a strategy I recommend to others. We decided instead to focus on the fundamental issues underlying all of these problems. We decided to focus on hope. We based this decision on our interviews with many of these young people in which they told us they didn't think they would live beyond the age of 20! Our view was that if these children, mostly from minority groups and mostly from very poor families, had no hope for the future, what

difference would it make if they smoked or used drugs or missed school or engaged in violent behavior? So we decided to work on hope and to help these children see that they could have a future. CDC received over 400 proposals from all over the country and I was amazed that they rated our proposal number 1 in the country. Even though we broke the rules. So it can be done.

In our work with these children, we decided, over a three-year period, to teach them ways of implementing their dreams. How to make things work for their benefit. How to select a problem and succeed in solving it. How to develop strategies for getting done what they want to get done. For having control over their destiny.

These kids are not very interested in talking about smoking or drugs or violence – our topic – but they can become interested in their future. The people we chose to work with them are high school students from their community along with selected undergraduates from the University at Berkeley. We did a wonderful job with these kids for 3 years. I would love to follow them into the future but where would I get money to do this. The Center of Disease Control has moved on to other interests and most other money sources remain interested in one or other specific disease. In my view, hope is one of the most important issues of all regarding health and well-being but hardly anyone else thinks that way. So we have not followed these kids to see how they are doing. And this failure is not good for MY health.

Our project on hope is of course a very different approach than the usual project directed to smoking, drugs and violence. We are trying in this project to focus not so much on OUR topics

but on the topics of concern to the kids. And to work with them as empowered partners. And we hope that the result will be lower rates of smoking and drug use, lower rates of inappropriate sexual behavior, and better school performance. But we may never know how all this works out.

Our study of San Francisco bus drivers offers another example of what I am trying to get at. We have been studying 2,000 of these bus drivers for many years now. The project started when a former student of mine became the Director of Health for San Francisco city employees and, as part of her job, supervised the physical exam for the bus drivers when they get their driving license renewed. She called me one day to say that she thought the prevalence of hypertension was too high and would I come and have a look. I did. And she was right. Among drivers over the age of 60, the prevalence of hypertension was 90%! So we applied for a research grant to study this problem in detail. We did all the things you would imagine and wrote several journal articles about the problem. Then we began to develop an intervention program to help the drivers.

Then we noticed that the drivers were complaining about a lot of back pain. We got another grant to study this problem and we wrote several journal articles about that. And we brought in some ergonomic experts to help with the redesign of the driver's seats and so on. Then we noticed that the drivers had high rates of gastrointestinal problems and respiratory difficulties. And recently we have observed that they have high rates of alcohol problems (after work – not while they are driving!). And we get research grants for everything and design interventions

for all of these problems and, while what we are doing is not a waste of time, it certainly is not going to solve the problem for the drivers. For example, even if we did a wonderful job on the blood pressures and the back pain and the stomach problems and the breathing difficulties and the drinking issue, as new drivers come to work for the bus company, they will soon exhibit the same disease profile as the old drivers because none of our work is addressing the fundamental problem. The fundamental problem is the job itself. We got so focused on the various specific disease problems of the drivers that we did not recognize the problem common to all the complaints: the job.

We therefore began a new project to see if we could figure out what it is about the job of bus driving that is problematic. It didn't take long to discover the problem. It is the schedule. In San Francisco, drivers must keep to the schedule but it cannot be done. For example, if you were to look at the schedule, you would see that you had to get from Mission and Army Street to Mission and Geneva Street in 2 minutes. It cannot be done. Even if you drove your Ferrari on Sunday morning with no traffic to contend with, it would take much longer than 2 minutes.

I always thought that a bus schedule was developed by driving a bus from stop to stop and seeing how long it took. That would be OK if you had lots of buses available. There is a shortage of buses in San Francisco and the schedule is therefore made by a computer that simply allocates times depending on the number of buses that are available. But then, drivers are penalized when they are late in arriving at the bus stop. The drivers compensate for this by giving up their rest stops at the end of the line. They just keep driving and hope to

minimize their lateness in this way. They dash into a MacDonald's when they need to use the bathroom and when they need food.

And since they are almost always late, passengers are almost always mad at them. The drivers feel that they are being unjustifiably blamed for a situation that is not in their control and they sometimes behave impolitely to passengers who then get upset with the driver. Then there is the traffic over which they have no control.

Most drivers have a terrible shift arrangement. They must come to work very early for the morning rush hour and they must be at work for the evening rush hour but they have nothing to do in the hours between these two intervals. There is generally not enough time to go home so the drivers generally hang around and do little. At the end of their very long day, they are usually completely worn out and many go to the local tavern to wind down. By the time they get home, they are often not in good shape for social interaction. They go to bed and get up at 4 AM to begin another grueling day.

Yes, they have hypertension and back pain and stomach and breathing and alcohol problems and they should be helped with those problems. But the job needs to be fixed. The management and bus drivers union have not been on the best terms for many years but they are willing to meet to discuss health issues. Management is motivated to do this because 1/3 of their budget has to be put aside to hire substitute drivers when regular drivers don't come to work. 1/3 of their budget! Further, they are concerned over the fact that so many drivers quit soon after they have completed a very expensive training program. And many others take

early retirement. At great cost to the company. And bus companies have high accident rates. The drivers are motivated to work with management for obvious reasons. So we are trying to solve this problem but it is very difficult. But we are working on issues that the drivers care deeply about and about control of destiny and we are focusing on fundamental underlying issues.

We have now been really trying hard at Berkeley to pay attention to the important issue of the community as an empowered partner. One of our projects that exemplifies this commitment is our work on the Wellness Guides. We have developed Guides for moms living in poverty, for people with disabilities, for people moving from welfare to work, for new mothers, and we are now working on one for older people. These guides are not what they sound like. They are each about 80 pages long with lots of pictures and personal stories and lots of advice on community resources. We have evaluated the usefulness of the Guides and I have been astonished that something I have done is really working. Unfortunately, this success is not due to my brilliance but to the fact that all of the Guides are developed in close partnership with people from the groups we are intending to reach. For example, the kids do most of the writing on the section on children, older people do most of the writing on the problem of aging, people with mental illness work on that topic, people with disabilities lead us on that topic, and so on. And most of the writing deals with the problems that people face in negotiating the world, not on the details of disease and risk factors.

I hope it is clear that I am not against medical treatment for people in pain and with disease. Nor am I against research to unravel the mysteries of the genome or to characterize disease

risk factors. My problem is that an overwhelmingly large part of the budget for health is focused on basic laboratory research and on medical care to the exclusion of work on disease prevention from a community perspective. Almost everyone in the health field is working on individually oriented research or medical care. Who is working on disease prevention in a community context and with the community as an empowered partner?

Let me share with you a made-up story I tell to beginning students in our Public Health class at the University in Berkeley, to get them thinking about this issue. I tell of a curvy road in the mountains where, at one point, cars fall off the cliff at a very high rate. And they crash at the bottom causing very serious damage. Head injuries. Spinal cord injuries. And the medical care at the bottom is not good. As a consequence, people have to be transported long distances, usually by helicopter or ambulance, to get help. Not good.

In my story, I suggest that we develop a health promotion and injury prevention program for this road. First, we will develop a hazard assessment and barrier program that will prohibit certain groups from driving on this road. Certain old people or people with vision and physical problems will be directed to take an alternative road. Those drivers who are permitted to proceed will have to submit to a behavioral intervention: a safe driving course. But we will also develop an environmental intervention by getting car manufacturers to reinforce the structure of cars that are permitted to proceed. And we will build a state-of-the-art medical facility at the bottom of the cliff. This new facility will have the best medical staff imaginable – neurosurgeons, orthopedic people, and other specialists. And we will remove all economic barriers for care so that everyone has universal access. And we will ensure that everyone gets

culturally appropriate medical treatment with language translation help when necessary. In short, we will do everything that it is now being recommended in first-rate health promotion and disease preventions programs.

In my classes, someone will eventually raise their hand and quietly ask, “How about fixing the road?” I then attack that person by asking how they can permit the diversion of funds from critically injured and bleeding people to do a highway construction project? Eventually, someone will tentatively suggest that if we don’t do the highway work, people will keep falling off the road. We eventually agree that a truly effective health promotion program must take account of the fundamental forces that cause our problems in the first place.

We don’t do very well in looking at fundamental forces in Public Health.

All of this can be boiled down, I think, to four fundamental issues.

1. It is important that we recognize the pervasiveness of funding mechanisms that reinforce a clinical, individual approach to disease. Most research grants are funded to deal with specific diseases, most training grants do the same, and most of you in this room today are probably working in programs that focus on a particular disease or a particular risk factor. This emphasis on diseases produces a group of disease or risk factor experts and it leads to intervention programs that focus on expert information on diseases and risk factors. This is OK as long as there are some programs in existence that focus on fundamental daily life issues that affect people’s lives. By addressing these people issues we have an opportunity to

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develop empowered partners in the community. If we do not do this, we increase the chances of failing to achieve our goals.

2. When we empower individuals, we must be conscious of the fact that we may be setting people up for frustration and failure. The reason for this is that even as we encourage people to control their own destiny, our interventions typically leave unchanged a variety of unfair and damaging environmental forces. The solution to this is to empower people with the recognition that empowerment is only one aspect of the problem and that they still have very difficult challenges ahead.

3. Inevitably, a focus on the environment and on the community requires that we think across the usual disciplinary lines that divide us. We do not do this very well. I was the graduation speaker at my School of Public Health a few years ago and I tried to discuss this in my talk. I noted that the students in the graduating class represented a very wide variety of disciplines: virology, endocrinology, medicine, mathematics, engineering, political science, geography, genetics, sociology, nutrition, anthropology, economics, to name just a few. And I indicated that while we all had different interests, we were all united in our desire to help make the world a better place. And I suggested that as they went forth to do that, they would likely fail because we at the University had failed them. We had trained them in disciplines but they would soon discover that the problems people face transcend those disciplines and involve schools, parks, roadways, housing, employment, schools. crime, politics and so on. They could come back to the University and point this out to us but we would not change. We faculty would not change because we were trained in disciplinary silos, we faculty receive

research and training grants that reinforce our silos and we will continue to train people as we had been trained. This is not good. And it is not likely to lead to collaboration with empowered community partners.

4. The fourth issue is one that I have not really addressed in this talk. I have emphasized that we have not done a very good job of helping people change their behavior. But, as we all know, people change their behavior all the time. On their own. Without our help. A good example of this is cigarette smoking. The prevalence of smoking in California has gone down from about 43% to less than 20% in recent years. This is a phenomenal achievement. And it far outstrips the successes we have had in one or another smoking cessation program. This is confronting: we set up programs to help people, most of them don't do what we want them to do, and, behind our backs, they make difficult changes on their own. The decline in smoking was due to a whole series of interventions: we learned a lot about smoking addiction from research in experimental psychology and we were able to apply that knowledge. And we learned about techniques of behavior change and were able to benefit from that knowledge as well. But we also informed people about the health risks of smoking. we raised the price of cigarettes, we limited access to cigarette machines, we enforced strict limitations on advertising in magazines and on billboards, and we outlawed smoking in many public places. We developed a health intervention that involved a wide variety of people and that went way beyond the narrow confines of the health field. Before we get too relaxed with this triumph, however, we need to be aware that kids are smoking at an increasing rate and, if present trends continue, it is conceivable that we will be back to a prevalence rate of 40% one day.

In fact, most of the successes we have achieved in behavior change have come about because they have been the subject of a multiple-pronged, multi-level, multidisciplinary approach. These approaches have involved information and research but they have also involved regulations and laws, mass media campaigns, workplace and other rules, better environmental engineering and design, and so on.

While we are on the topic of successes, there is another success that I have not dealt with. I have been complaining that our interventions on coronary heart disease have failed. And yet, in the United States, we have since 1970 or so witnessed a tremendous decline in death rates from this disease – one of the most dramatic declines in disease ever recorded. Coronary heart disease is still the number one cause of death in the U.S. but the decline in mortality is an impressive achievement. So why am I complaining so loudly about failures? Obviously, we are doing something right. And we are. But as is true for most topics, this is a complicated issue. While the death rate has gone down, there is evidence to suggest that the number of people developing heart disease has stayed about the same. People are just not dying from the disease as often as they did in years past. Medical care is better. And with this improvement in medical care comes an even larger gap in health between those at the top and bottom of the social class gradient. This gap has grown progressively larger over the years. So we have a long way to go before we can relax with our success.

These are difficult issues. I have struggled mightily with them for many years. Especially difficult is the problem of working with members of the community as empowered partners. There was a time when I would meet with members from the community to talk to them

about our common interests and I would be shocked that, while I was making my speech, they weren't even taking notes! And then they would interrupt me in mid presentation. I used to go home saying I wasn't going to work with THEM anymore. Then, later, I would realize that that was not a very mature or considered judgment and I would solve the problem by sending OTHER people from my team to meet with them.

It was only years later that I truly began to get the real point. We in Public Health are training a group of experts in our Universities but we really need to begin to train a different kind of expert. This is not an ideological position. It is a very practical issue. We all know that the medical care system is under enormous strain in both of our countries. And we all know that the baby boomers will soon be entering the over-65 age group. When they do, beginning in 2011, the number of older people in our countries will double. If we think our medical care system is in trouble now, we ain't seen nothin' yet. Our only hope is to develop better strategies for preventing disease and promoting health and not simply waiting to fix problems after they occur. And to do that, we will have to work with the community as empowered partners. And to do THAT, we will have to fundamentally change our public health model: we will have to change the way we classify disease, we will have to train a new generation of experts, we will have to change the way we organize and finance public health education and research, and we will have to deal with our arrogance.

Of course, the importance of working more closely with the community transcends the issue of health. In these difficult economic times, it is crucial for us to support one another, to see that we are all in this together, that what affects some of us affects all of us. If ever there was

a time to bring to life the social contract, it is now. The importance of community has perhaps never been more important for our common well-being.

It is unfortunate that we are now forced to recognize this fact because our health programs are failing and because our economies are failing and because we face other crises and disasters but let us rejoice that we now have an opportunity to recognize and celebrate our humanity. This is clearly the time to rebuild, renew and recharge. This is a difficult and challenging imperative but we really have no choice.

Thank you