

U N I T  
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# FOUNDATIONS OF COMMUNITY HEALTH





## Chapter 1

# Community Health: Yesterday, Today, and Tomorrow

### Chapter Outline

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Definitions • Factors That Affect the Health of a Community

#### A Brief History of Community and Public Health

Earliest Civilizations • The Eighteenth Century • The Nineteenth Century • The Twentieth Century

#### Outlook for Community Health in the Twenty-First Century

World Planning for the Twenty-First Century • The United States' Planning for the Twenty-First Century

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### Chapter Objectives

After studying this chapter, you will be able to:

- 1 Accurately define the terms *health*, *community*, *community health*, *population health*, *public health*, *public health system*, and *global health*.
- 2 Briefly describe the five major determinants of health.
- 3 Explain the difference between personal and community health activities.
- 4 List and discuss the factors that influence a community's health.
- 5 Briefly relate the history of community/public health, including the recent U.S. history of community and public health in the twentieth and early twenty-first centuries.
- 6 Provide a brief overview of the current health status of Americans.
- 7 Describe the major community health problems facing the United States today.
- 8 Describe the status of efforts to improve world health and list some plans for the future.
- 9 Describe the purpose of the *Healthy People 2020* goals and objectives as they apply to the planning process of the health of Americans.

## SCENARIO

Amy and Eric are a young working couple who are easing into a comfortable lifestyle. They have good-paying jobs, drive nice cars, are buying a home in a good neighborhood, and have two healthy preschool children. When Amy picked her children up from day care earlier in the day she learned from the head teacher that another parent had reported that his child was diagnosed with hepatitis. This news frightened Amy and made her begin to question the quality of the day care center. Amy told Eric of this situation when he got home from work. As the couple discussed whether or not they should take

their children to day care as usual the following day, they discovered that they have many unanswered questions. How serious is hepatitis? What is the likelihood that their children will be at serious risk for getting the disease? What steps are being taken to control the outbreak? Is any state or local agency responsible for standardizing health practices at private day care centers in the community? Does the city, county, or state carry out any type of inspection when they license these facilities? And, if the children do not attend day care, which parent will stay home with them?

## INTRODUCTION

In looking back over the last 100-plus years, it is easy to point to the tremendous progress that was made in the health and life expectancy of those in the United States (see Box 1.1) and of many people of the world. Infant mortality dropped, many of the infectious diseases have been brought under control, and better family planning became available. However, there is still room for improvement! Individual health behaviors, such as the use of tobacco, poor diet, and physical inactivity, have given rise to an unacceptable number of cases of illness and death from noninfectious diseases such as cancer, diabetes, and heart disease. New and emerging infectious diseases, such as the 2009 H1N1 flu and those caused by drug-resistant pathogens, are stretching resources available to control them. And events stemming from natural disasters such as floods and hurricanes, and humanmade disasters such as the Gulf oil spill and terrorism around the world have caused us to refocus our priorities. All of these events have severely disrupted Americans' sense of security<sup>1</sup> and sense of safety in the environment. In addition, many of these events revealed the vulnerability of the United States' ability to respond to such circumstances and highlighted the need for improvement in emergency response preparedness and infrastructure of the public health system.

Even with all that has happened in recent years in the United States and around the world, the achievement of good health remains a worldwide goal of the twenty-first century. Governments, private organizations, and individuals throughout the world are working to improve health. Although individual actions to improve one's own personal health certainly contribute to the overall health of the community, organized community actions are often necessary when health problems exceed the resources of any one individual. When such actions are not taken, the health of the entire community is at risk.

This chapter introduces the concepts and principles of community health, explains how community health differs from personal health, and provides a brief history of community health. Some of the key health problems facing Americans are also described, and an outlook for the twenty-first century is provided.

BOX  
1.1

## A LOOK BACK ON THE TWENTIETH CENTURY IN THE UNITED STATES

As the twentieth century came to a close, the overall health status and life expectancy in the United States were at all-time highs. Since 1900, the average life span of people in the United States had lengthened by more than 30 years; 25 of these years have been attributed to advances in public health.<sup>2</sup> There were many public health achievements that can be linked to this gain in life expectancy, however. The Centers for Disease Control and Prevention (CDC), the U.S. government agency charged with protecting the public health of the nation, singled out the “Ten Great Public Health Achievements” in the United States between 1900 and 1999. Some of these achievements will be discussed in greater detail in other chapters of this book where they are more relevant to the content being presented. Here is the entire list:<sup>3</sup>

1. *Vaccination.* Vaccines are now available to protect children and adults against 15 life-threatening or debilitating diseases. Rates of all vaccine-preventable diseases are down more than 97% from peak levels before vaccines were available.<sup>4</sup>
2. *Motor vehicle safety.* A number of advances over the years, including safety belts, air bags, safer cars and roads, and enforcement of drunk driving and other laws, have saved many lives.<sup>4</sup>
3. *Safer workplaces.* A number of voluntary and mandatory practices in the workplace have created a much safer work environment. In the early 1900s, the work-related death rate was about 21 per 100,000. By the mid-1990s, that number had dropped to about 4 per 100,000.<sup>5</sup>
4. *Control of infectious diseases.* At the beginning of the twentieth century, the leading causes of death were infectious diseases, but by mid-century many of these diseases were under control. This control can be attributed to cleaner water, improved sanitation, and antibiotics.
5. *Decline of deaths from coronary heart disease and stroke.* Although these remain the leading causes of death, significant progress has been made in reducing the death rates since 1950. This progress can be attributed to the identification and modification of risk factors such as smoking and high blood pressure, and the improved access to early detection and better treatment.
6. *Safer and healthier foods.* Over the twentieth century much of the microbial contamination of food has been significantly reduced, and the nutritional value of foods has been greatly enhanced.
7. *Healthier mothers and babies.* Infant and maternal mortality rates have decreased 90% and 99%, respectively. This can be attributed to advances in hygiene, nutrition, antibiotics, medical technology, and access to health care.
8. *Family planning.* Advances in family planning and contraceptive services have provided for greater health benefits for mothers and babies and have reduced the transmission of several sexually transmitted diseases.
9. *Fluoridation of drinking water.* Though fluoridation of water only began in the mid-twentieth century, it has played an important role in the reduction of both tooth decay and tooth loss.
10. *Recognition of tobacco use as a health hazard.* Recognition of tobacco as the single most preventable cause of death in the United States has saved the lives and suffering of millions of people in this country.

## Definitions

The word *health* means different things to different people. Similarly, there are other words that can be defined in various ways. Some basic terms we will use in this book are defined in the following paragraphs.

### Health

The word *health* is derived from *hal*, which means “hale, sound, whole.” When it comes to the health of people, the word *health* has been defined in a number of different ways—often in its social context, as when a parent describes the health of a child or when an avid fan defines the health of a professional athlete. The most widely quoted definition of health was the one created by the World Health Organization (WHO) in 1946. That definition states that

**health**

a dynamic state or condition of the human organism that is multidimensional in nature, a resource for living, and results from a person's interactions with and adaptations to his or her environment; therefore, it can exist in varying degrees and is specific to each individual and his or her situation

“health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity.”<sup>6</sup> Further, the WHO has indicated that “health is a resource for everyday life, not the object of living, and is a positive concept emphasizing social and personal resources as well as physical capabilities.”<sup>6</sup> Others have stated that health cannot be defined as a state because it is ever changing. Therefore, we have chosen to define **health** as a *dynamic* state or condition of the human organism that is multidimensional (i.e., physical, emotional, social, intellectual, spiritual, and occupational) in nature, a resource for living, and results from a person's interactions with and adaptations to his or her environment. Therefore, it can exist in varying degrees and is specific to each individual and his or her situation. “For example, a person can be healthy while dying, or a person who is a quadriplegic can be healthy in the sense that his or her mental and social well-being are high and physical health is as good as it can be.”<sup>7</sup>

A person's health status is dynamic in part because of the many different factors that determine one's health. It is widely accepted that health status is determined by the interaction of five domains: gestational endowments (i.e., genetic makeup), social circumstances (e.g., education, employment, income, poverty, housing, crime, and social cohesion), environmental conditions where people live and work (i.e., toxic agents, microbial agents, and structural hazards), behavioral choices (e.g., diet, physical activity, substance use and abuse), and the availability of quality medical care.<sup>8</sup> “Ultimately, the health fate of each of us is determined by factors acting not mostly in isolation but by our experience where domains interconnect. Whether a gene is expressed can be determined by environmental exposures or behavioral patterns. The nature and consequences of behavioral choices are affected by social circumstances. Our genetic predispositions affect the health care we need, and our social circumstances affect the health care we receive.”<sup>9</sup>

**Community**

Traditionally, a community has been thought of as a geographic area with specific boundaries—for example, a neighborhood, city, county, or state. However, in the context of community health, a **community** is “a group of people who have common characteristics; communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or common bonds.”<sup>10</sup> Today we can even talk about a cyber community.<sup>11</sup> Communities are characterized by the following elements:

- (1) membership—a sense of identity and belonging; (2) common symbol systems—similar language, rituals, and ceremonies; (3) shared values and norms; (4) mutual influence—community members have influence and are influenced by each other; (5) shared needs and commitment to meeting them; and (6) shared emotional connection—members share common history, experiences, and mutual support.<sup>12</sup>

Examples of communities include the people of the city of Columbus (location), the Asian community of San Francisco (race), the Hispanic community of Miami (ethnicity), seniors in the church (age), the business or the banking communities (occupation), the homeless of Indiana (specific problem), those on welfare in Ohio (particular outcome), local union members (common bond), or those who are members of a social network (cyber). A community may be as small as the group of people who live on a residence hall floor at a university or as large as all of the individuals who make up a nation. “A healthy community is a place where people provide leadership in assessing their own resources and needs, where public health and social infrastructure and policies support health, and where essential public health services, including quality health care, are available.”<sup>13</sup>

**community**

a group of people who have common characteristics; communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other common bonds

### ***Public, Community, Population, and Global Health***

Prior to defining the four terms *public health*, *community health*, *population health*, and *global health*, it is important to note that often the terms are used interchangeably by both laypeople and professionals who work in the various health fields. When the terms are used interchangeably, most people are referring to the collective health of those in society and the actions or activities taken to obtain and maintain that health. The definitions provided here for the four terms more precisely define the group of people in question and the origin of the actions or activities.

Of the four terms, *public health* is the most inclusive. The Institute of Medicine (IOM) defined **public health** in 1988 in its landmark report *The Future of Public Health* as “what we as a society do collectively to assure the conditions in which people can be healthy.”<sup>14</sup> The **public health system**, which has been defined as “activities undertaken within the formal structure of government and the associated efforts of private and voluntary organizations and individuals,”<sup>14</sup> is the organizational mechanism for providing such conditions. Even with these formal definitions, some still see public health activities as only those efforts that originate in federal, state, and local governmental public health agencies such as the Centers for Disease Control and Prevention and local (i.e., city and county) health departments.

**Community health** refers to the health status of a defined group of people and the actions and conditions to promote, protect, and preserve their health. For example, the health status of the people of Muncie, Indiana, and the private and public actions taken to promote, protect, and preserve the health of these people would constitute community health.

The term *population health* is similar to *community health*. The primary difference between these two terms is the degree of organization or identity of the people. **Population health** refers to the health status of people who are not organized and have no identity as a group or locality and the actions and conditions to promote, protect, and preserve their health. Men younger than 50, adolescents, prisoners, and white-collar workers are all examples of populations.<sup>15</sup>

A term that has been used increasingly more in recent years is *global health*. The term “does not have one uniform definition. Several organizations have defined the term, and they generally use it in three different ways: (1) as a state or condition; (2) as a goal; and (3) as a field of study, research, and practice.”<sup>16</sup> For our discussion here, and to keep it parallel with the terms we have already defined, we use a definition that defines it as a state or condition. Thus, **global health** is a term that describes “health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions.”<sup>17</sup> Therefore, an issue such as the 2009 H1N1 flu pandemic can be viewed as a global health issue. Much of the rise in concern about global health problems comes from the speed of international travel and how easy it is for people who may be infected with a disease to cross borders into another country.

### ***Personal Health versus Community Health***

To further clarify the definitions presented in this chapter, it is important to distinguish between the terms *personal health activities* and *community health activities*.

#### ***Personal Health Activities***

Personal health activities are individual actions and decision making that affect the health of an individual or his or her immediate family members or friends. These activities may be preventive or curative in nature but seldom directly affect the behavior of others. Choosing to eat

**public health**  
actions that society takes collectively to ensure that the conditions in which people can be healthy can occur

**public health system**  
the organizational mechanism of those activities undertaken within the formal structure of government and the associated efforts of private and voluntary organizations and individuals

**community health**  
the health status of a defined group of people and the actions and conditions to promote, protect, and preserve their health

**population health**  
the health status of people who are not organized and have no identity as a group or locality and the actions and conditions to promote, protect, and preserve their health

**global health**  
describes health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions

wisely, to regularly wear a safety belt, and to visit the physician are all examples of personal health activities.

### *Community Health Activities*

Community health activities are activities that are aimed at protecting or improving the health of a population or community. Maintenance of accurate birth and death records, protection of the food and water supply, and participating in fund drives for voluntary health organizations such as the American Lung Association are examples of community health activities.

Within this book, you are introduced to the many community health activities and to the organizations that are responsible for carrying them out. The following are some of the key topics that are covered in this text:

- Organizations that contribute to community health
- How communities measure health, disease, injury, and death
- Control of communicable and noncommunicable diseases
- How communities organize to solve health problems
- Community health in schools
- Community health needs of people at different stages of life
- Community health needs of special populations
- Community mental health
- Abuse of alcohol, tobacco, and other drugs
- The health care delivery system
- Environmental health problems
- Intentional and unintentional injuries
- Occupational safety and health

## Factors That Affect the Health of a Community

There are a great many factors that affect the health of a community. As a result, the health status of each community is different. These factors may be physical, social, and/or cultural. They also include the ability of the community to organize and work together as a whole as well as the individual behaviors of those in the community (see Figure 1.1).

### *Physical Factors*

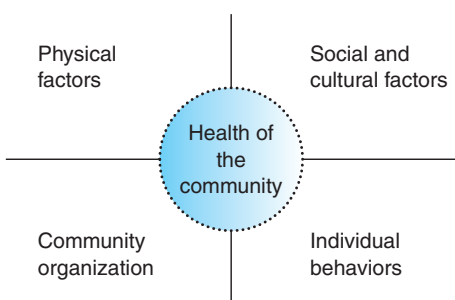
Physical factors include the influences of geography, the environment, community size, and industrial development.

### *Geography*

A community's health problems can be directly influenced by its altitude, latitude, and climate. In tropical countries where warm, humid temperatures and rain prevail throughout the year, parasitic and infectious diseases are a leading community health problem (see Figure 1.2). In many tropical countries, survival from these diseases is made more difficult because poor soil conditions result in inadequate food production and malnutrition. In temperate climates with fewer parasitic and infectious diseases and a more than adequate food supply, obesity and heart disease are important community health problems.

**FIGURE 1.1**

Factors that affect the health of a community.



### *Environment*

The quality of our environment is directly related to the quality of our stewardship of it. Many experts believe that if we continue to allow uncontrolled population growth and continue to deplete nonrenewable natural resources, succeeding generations will inhabit communities that are less desirable than ours. Many feel that we must accept responsibility for this stewardship and drastically reduce the rate at which we foul the soil, water, and air.

### *Community Size*

The larger the community, the greater its range of health problems and the greater its number of health resources. For example, larger communities have more health professionals and better health facilities than smaller communities. These resources are often needed because communicable diseases can spread more quickly and environmental problems are often more severe in densely populated areas. For example, the amount of trash generated by the approximately 8.3 million people in New York City is many times greater than that generated by the entire state of Wyoming, with its population of about 544,270.

It is important to note that a community's size can have both a positive and negative impact on that community's health. The ability of a community to effectively plan, organize, and utilize its resources can determine whether its size can be used to good advantage.

### *Industrial Development*

Industrial development, like size, can have either positive or negative effects on the health status of a community. Industrial development provides a community with added resources for community health programs, but it may bring with it environmental pollution and occupational injuries and illnesses. Communities that experience rapid industrial development must eventually regulate the way in which industries (1) obtain raw materials, (2) discharge by-products, (3) dispose of wastes, (4) treat and protect their employees, and (5) clean up environmental accidents. Unfortunately, many of these laws are usually passed only after these communities have suffered significant reductions in the quality of their life and health.

### *Social and Cultural Factors*

Social factors are those that arise from the interaction of individuals or groups within the community. For example, people who live in urban communities, where life is fast-paced, experience higher rates of stress-related illnesses than those who live in rural communities, where life is more leisurely. On the other hand, those in rural areas may not have access to the same quality or selection of health care (i.e., hospitals or medical specialists) that is available to those who live in urban communities.

Cultural factors arise from guidelines (both explicit and implicit) that individuals "inherit" from being a part of a particular society. Culture "teaches us what to fear, what to respect, what to value, and what to regard as relevant in our lives."<sup>18</sup> Some of the factors that contribute to culture are discussed in the following sections.

### *Beliefs, Traditions, and Prejudices*

The beliefs, traditions, and prejudices of community members can affect the health of the community. The beliefs of those in a community about such specific health behaviors as exercise and smoking can influence policy makers on whether or not they will spend money on bike trails and work toward no-smoking ordinances. The traditions of specific ethnic



**FIGURE 1.2**

In tropical countries, parasitic and infectious diseases are leading community health problems.

groups can influence the types of food, restaurants, retail outlets, and services available in a community. Prejudices of one specific ethnic or racial group against another can result in acts of violence and crime. Racial and ethnic disparities will continue to put certain groups, such as black Americans or certain religious groups, at greater risk.

### *Economy*

Both national and local economies can affect the health of a community through reductions in health and social services. An economic downturn means lower tax revenues (fewer tax dollars) and fewer contributions to charitable groups. Such actions will result in fewer dollars being available for programs such as welfare, food stamps, community health care, and other community services. This occurs because revenue shortfalls cause agencies to experience budget cuts. With less money, these agencies often must alter their eligibility guidelines, thereby restricting aid to only the neediest individuals. Obviously, many people who had been eligible for assistance before the economic downturn become ineligible.

Employers usually find it increasingly difficult to provide health benefits for their employees as their income drops. The unemployed and underemployed face poverty and deteriorating health. Thus, the cumulative effect of an economic downturn significantly affects the health of the community.

### *Politics*

Those who happen to be in political office can improve or jeopardize the health of their community by the decisions they make. In the most general terms, the argument is over greater or lesser governmental participation in health issues. For example, there has been a long-standing discussion in the United States on the extent to which the government should involve itself in health care. Historically, Democrats have been in favor of such action while Republicans have been against it. State and local politicians also influence the health of their communities each time they vote on health-related measures brought before them, such as a no-smoking ordinance.

### *Religion*

A number of religions have taken a position on health care and health behaviors. For example, some religious communities limit the type of medical treatment their members may receive. Some do not permit immunizations; others do not permit their members to be

treated by physicians. Still others prohibit certain foods. For example, kosher dietary regulations permit Jews to eat the meat only of animals that chew cud and have cloven hooves and the flesh only of fish that have both gills and scales, while still others, like the Native American Church of the Morning Star, use peyote, a hallucinogen, as a sacrament.

Some religious communities actively address moral and ethical issues such as abortion, premarital intercourse, and homosexuality. Still other religions teach health-promoting codes of living to their members. Obviously, religion can affect a community's health positively or negatively (see Figure 1.3).

### *Social Norms*

The influence of social norms can be positive or negative and can change over time. Cigarette smoking is a good example. During the 1940s, 1950s, and 1960s, it was socially acceptable to smoke in most settings. As a matter of fact, in 1960, 53% of American men and 32% of American women smoked. Thus, in 1960 it was socially acceptable to be a smoker, especially if you were male. Now, early



**FIGURE 1.3**

Religion can affect a community's health either positively or negatively.

in the twenty-first century, those percentages have dropped to 23.1% (for males) and 18.3% (for females), and in most public places it has become socially unacceptable to smoke.<sup>19</sup> The lawsuits against tobacco companies by both the state attorneys general and private citizens provide further evidence that smoking has fallen from social acceptability. Because of this change in the social norm, there is less secondhand smoke in many public places, and in turn the health of the community has improved.

Unlike smoking, alcohol consumption represents a continuing negative social norm in America, especially on college campuses. The normal expectation seems to be that drinking is fun (and almost everyone wants to have fun). Despite the fact that most college students are too young to drink legally, approximately 60% of college students drink.<sup>20</sup> It seems fairly obvious that the American alcoholic-beverage industry has influenced our social norms.

### *Socioeconomic Status*

Differences in socioeconomic status, whether “defined by education, employment, or income, both individual- and community-level socioeconomic status have independent effects on health.”<sup>21</sup> “In the United States today, the health of poor people is threatened by the adverse environmental conditions of the inner cities, such as lead paint and air pollution, crime, and violence. Poor people also have poorer nutrition, less access to medical care, and more psychological stress.”<sup>21</sup> In addition to health care access, higher incomes enable people to afford better housing, live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors.<sup>22</sup>

### *Community Organizing*

The way in which a community is able to organize its resources directly influences its ability to intervene and solve problems, including health problems. **Community organizing** “is a process through which communities are helped to identify common problems or goals, mobilize resources, and in other ways develop and implement strategies for reaching their goals they have collectively set.”<sup>23</sup> It is not a science but an art of building consensus within a democratic process.<sup>24</sup> If a community can organize its resources effectively into a unified force, it “is likely to produce benefits in the form of increased effectiveness and productivity by reducing duplication of efforts and avoiding the imposition of solutions that are not congruent with the local culture and needs.”<sup>13</sup> For example, many communities in the United States have faced community-wide drug problems. Some have been able to organize their resources to reduce or resolve these problems, whereas others have not. (See Chapter 5 for a full explanation of community organizing.)

### *Individual Behavior*

The behavior of the individual community members contributes to the health of the entire community. It takes the concerted effort of many—if not most—of the individuals in a community to make a program work. For example, if each individual consciously recycles his or her trash each week, community recycling will be successful. Likewise, if each occupant would wear a safety belt, there could be a significant reduction in the number of facial injuries and deaths from car crashes for the entire community. In another example, the more individuals who become immunized against a specific disease, the slower the disease will spread and the fewer people will be exposed. This concept is known as **herd immunity**.

**community organizing**  
a process through which communities are helped to identify common problems or goals, mobilize resources, and in other ways develop and implement strategies for reaching their goals they have collectively set

**herd immunity**  
the resistance of a population to the spread of an infectious agent based on the immunity of a high proportion of individuals

## A BRIEF HISTORY OF COMMUNITY AND PUBLIC HEALTH

The history of community and public health is almost as long as the history of civilization. This brief summary provides an account of some of the accomplishments and failures in

**FIGURE 1.4**

Archeological findings reveal community health practices of the past.

community and public health. It is hoped that a knowledge of the past will enable us to better prepare for future challenges to our community's health.

### Earliest Civilizations

In all likelihood, the earliest community health practices went unrecorded. Perhaps these practices involved taboos against defecation within the tribal communal area or near the source of drinking water. Perhaps they involved rites associated with burial of the dead. Certainly, the use of herbs for the prevention and curing of diseases and communal assistance with childbirth are practices that predate archeological records.

Excavations at sites of some of the earliest known civilizations, dating from about 2000 B.C., have uncovered archeological evidence of community health activities (see Figure 1.4). A combination of additional archeological findings and written history provides much more evidence of community health activities through the seventeenth century. Box 1.2 provides a timeline and some of the highlights of that history for the Ancient Societies (before 500 B.C.), the Classical Cultures (500 B.C.–A.D. 500), the Middle Ages (A.D. 500–1500), and the period of Renaissance and Exploration (1500–1700)

### The Eighteenth Century

The eighteenth century was characterized by industrial growth. Despite the beginnings of recognition of the nature of disease, living conditions were hardly conducive to good health. Cities were overcrowded, and water supplies were inadequate and often unsanitary. Streets were usually unpaved, filthy, and heaped with trash and garbage. Many homes had unsanitary dirt floors.

Workplaces were unsafe and unhealthy. A substantial portion of the workforce was made up of the poor, which included children, who were forced to work long hours as indentured servants. Many of these jobs were unsafe or involved working in unhealthy environments, such as textile factories and coal mines.

One medical advance made at the end of the eighteenth century deserves mention because of its significance for public health. In 1796, Dr. Edward Jenner successfully demonstrated the process of vaccination as a protection against smallpox. He did this by inoculating a boy with material from a cowpox (*Vaccinia*) pustule. When challenged later with material from a smallpox (*Variola*) pustule, the boy remained healthy.

Dr. Jenner's discovery remains as one of the great discoveries of all time for both medicine and for public health. Prior to Dr. Jenner's discovery, millions died or were severely disfigured by smallpox (see Figure 1.5). The only known prevention had been "variolation," inoculation with smallpox material itself. This was a risky procedure because people sometimes became quite ill with smallpox. Nonetheless, during the American Revolution, General George Washington ordered the Army of the American Colonies "variolated." He did this so that he could be sure an epidemic of smallpox would not wipe out his colonial forces.<sup>27</sup> Interestingly enough, the average age at death for one living in the United States during this time was 29 years.

Following the American Revolution, George Washington ordered the first U.S. census for the purpose of the apportionment of representation in the House of Representatives. The

BOX  
1.2

## TIMELINE AND HIGHLIGHTS OF COMMUNITY AND PUBLIC HEALTH PRIOR TO 1700

## A. Early Civilizations

## 1. Ancient Societies (before 500 B.C.)

- a. Prior to 2000 B.C.: Archeological findings provide evidence of sewage disposal and written medical prescriptions.
- b. Circa 1900 B.C.: Perhaps the earliest written record of public health was the Code of Hammurabi; included laws for physicians and health practices.<sup>25</sup>
- c. Circa 1500 B.C.: Bible's Book of Leviticus written; includes guidelines for personal cleanliness and sanitation.<sup>25</sup>

## 2. Classical Cultures (500 B.C.–A.D. 500)

- a. Fifth and sixth centuries B.C.: Evidence that Greek men participated in games of strength and skill and swam in public facilities.<sup>26</sup>
- b. Greeks were involved in practice of community sanitation; involved in obtaining water from sources far away and not just local wells.<sup>27</sup>
- c. Romans were community minded; improved on community sanitation of Greeks; built aqueducts to transport water from miles away; built sewer systems; created regulation for building construction, refuse removal, and street cleaning and repair;<sup>25</sup> created hospitals as infirmaries for slaves.<sup>28</sup>
- d. Christians created hospitals as benevolent charitable organizations.<sup>28</sup>
- e. A.D. 476: Roman Empire fell and most public health activities ceased.

## B. Middle Ages (A.D. 500–1500)

- a. A.D. 500–1000 (Dark Ages): Growing revulsion for Roman materialism and a growth of spirituality; health problems were considered to have both spiritual causes and spiritual solutions;<sup>28</sup> time referred to as the **spiritual era of public health**.

- b. Failure to take into account the role of the physical and biological environment in the causation of communicable diseases resulted in many unremitting epidemics in which millions suffered and died.

- Deadliest epidemics were from plague (“black death”); occurred in A.D. 543 and 1348 (this one killed 25 million; half of population of London lost and in some parts of France only 1 in 10 survived).<sup>25</sup>
- A.D. 1200: More than 19,000 leper houses.
- Other epidemics of period: Smallpox, diphtheria, measles, influenza, tuberculosis, anthrax, and trachoma.
- A.D. 1492: Syphilis epidemic was last epidemic of the period.

## C. Renaissance and Exploration (1500–1700)

- a. Rebirth of thinking about the nature of world and humankind.
- b. Belief that disease was caused by environmental, not spiritual, factors; for example, the term *malaria*, meaning bad air, is a direct reference to humid or swampy air.
- c. Observation of ill led to more accurate descriptions of symptoms and outcomes of diseases; observations led to first recognition of whooping cough, typhus, scarlet fever, and malaria as distinct and separate diseases.<sup>27</sup>
- d. Epidemics (e.g., smallpox, malaria, and plague) still rampant; plague epidemic killed 68,596 (15% of the population) in London in 1665.
- e. Explorers, conquerors, and merchants and their crews spread disease to colonists and indigenous people throughout the New World.

census, first taken in 1790, is still conducted every 10 years and serves as an invaluable source of information for community health planning.

As the eighteenth century came to a close, a young United States faced numerous disease problems, including continuing outbreaks of smallpox, cholera, typhoid fever, and yellow fever. Yellow fever outbreaks usually occurred in port cities such as Charleston, Baltimore, New York, and New Orleans, where ships arrived to dock from tropical America. The greatest single epidemic of yellow fever in America occurred in Philadelphia in 1793, where there were an estimated 23,000 cases, including 4,044 deaths in a population estimated at only 37,000.<sup>29</sup>

In response to these continuing epidemics and the need to address other mounting health problems, such as sanitation and protection of the water supply, several governmental

**spiritual era of public health**  
a time during the Middle Ages when the causation of communicable disease was linked to spiritual forces



**FIGURE 1.5**

Prior to the elimination of smallpox, millions died or were severely disfigured by the disease.

health agencies were created. In 1798, the Marine Hospital Service (forerunner to the U.S. Public Health Service) was formed to deal with disease that was occurring onboard water vessels. By 1799, several of America's largest cities, including Boston, Philadelphia, New York, and Baltimore, also had founded municipal boards of health.

### The Nineteenth Century

During the first half of the nineteenth century, few remarkable advancements in public health occurred. Living conditions in Europe and England remained unsanitary, and industrialization led to an even greater concentration of the population within cities. However, better agricultural methods led to improved nutrition for many.

During this period, America enjoyed westward expansion, characterized by a spirit of pioneering, self-sufficiency, and rugged individualism. The federal government's approach to health problems was characterized by the French term *laissez faire*, meaning noninterference. There were also few health regulations or health departments in rural areas. Health quackery thrived; this was truly a period when "buyer beware" was good advice.

Epidemics continued in major cities in both Europe and America. In 1854, another cholera epidemic struck London. Dr. John Snow studied the epidemic and hypothesized that the disease was being caused by the drinking water from the Broad Street pump. He obtained permission to remove the pump handle, and the epidemic was abated (see Figure 1.6). Snow's action was remarkable because it predated the discovery that microorganisms can cause disease. The predominant theory of contagious disease at the time was the "miasmas theory." According to this theory, vapors, or miasmas, were the source of many diseases. The miasmas theory remained popular throughout much of the nineteenth century.

In the United States in 1850, Lemuel Shattuck drew up a health report for the Commonwealth of Massachusetts that outlined the public health needs for the state. It included recommendations for the establishment of boards of health, the collection of vital statistics, the implementation of sanitary measures, and research on diseases. Shattuck also recommended health education and controlling exposure to alcohol, smoke, adulterated food, and nostrums (quack medicines).<sup>25</sup> Although some of his recommendations took years to implement (the Massachusetts Board of Health was not founded until 1869), the significance of Shattuck's report is such that 1850 is a key date in American public health; it marks the beginning of the **modern era of public health**.

Real progress in the understanding of the causes of many communicable diseases occurred during the last quarter of the nineteenth century. One of the obstacles to progress was the theory of spontaneous generation, the idea that living organisms could arise from inorganic or nonliving matter. Akin to this idea was the thought that one type of contagious microbe could change into another type of organism.

In 1862, Louis Pasteur of France proposed his germ theory of disease. Throughout the 1860s and 1870s, he and others carried out experiments and made observations that supported this theory and disproved spontaneous generation. Pasteur is generally given credit for providing the death blow to the theory of spontaneous generation.

It was the German scientist Robert Koch who developed the criteria and procedures necessary to establish that a particular microbe, and no other, causes a particular disease. His first demonstration, with the anthrax bacillus, was in 1876. Between 1877 and the end of the century, the identity of numerous bacterial disease agents was established, including

modern era of public health  
the era of public health that began in 1850 and continues today

those that caused gonorrhea, typhoid fever, leprosy, tuberculosis, cholera, diphtheria, tetanus, pneumonia, plague, and dysentery. This period (1875–1900) has come to be known as the **bacteriological period of public health**.

Although most scientific discoveries in the late nineteenth century were made in Europe, there were significant public health achievements occurring in America as well. The first law prohibiting the adulteration of milk was passed in 1856, the first sanitary survey was carried out in New York City in 1864, and the American Public Health Association was founded in 1872. The Marine Hospital Service gained new powers of inspection and investigation under the Port Quarantine Act of 1878.<sup>25</sup> In 1890, the pasteurization of milk was introduced, and in 1891 meat inspection began. It was also during this time that nurses were first hired by industries (in 1895) and schools (in 1899). Also in 1895, septic tanks were introduced for sewage treatment. In 1900, Major Walter Reed of the U.S. Army announced that yellow fever was transmitted by mosquitoes.

## The Twentieth Century

As the twentieth century began, life expectancy was still less than 50 years.<sup>30</sup> The leading causes of death were communicable diseases— influenza, pneumonia, tuberculosis, and infections of the gastrointestinal tract. Other communicable diseases, such as typhoid fever, malaria, and diphtheria, also killed many people.

There were other health problems as well. Thousands of children were afflicted with conditions characterized by noninfectious diarrhea or by bone deformity. Although the symptoms of pellagra and rickets were known and described, the causes of these ailments remained a mystery at the turn of the century. Discovery that these conditions resulted from vitamin deficiencies was slow because some scientists were searching for bacterial causes.

Vitamin deficiency diseases and one of their contributing conditions, poor dental health, were extremely common in the slum districts of both European and American cities. The unavailability of adequate prenatal and postnatal care meant that deaths associated with pregnancy and childbirth were also high.

### *Health Resources Development Period (1900–1960)*

Much growth and development took place during the 60-year period from 1900 to 1960. Because of the growth of health care facilities and providers, this period of time is referred to as the **health resources development period**. This period can be further divided into the reform phase (1900–1920), the 1920s, the Great Depression and World War II, and the postwar years.

#### *The Reform Phase (1900–1920)*

By the beginning of the twentieth century, there was a growing concern about the many social problems in America. The remarkable discoveries in microbiology made in the previous years had not dramatically improved the health of the average citizen. By 1910, the urban population had grown to 45% of the total population (up from 19% in 1860). Much of the growth was the result of immigrants who came to America for the jobs created by new industries (see Figure 1.7). Northern cities were also swelling from the northward migration of black Americans from the southern states. Many of these workers had to accept poorly



**FIGURE 1.6**

In London, England, 1854, John Snow helped interrupt a cholera epidemic by having the handle removed from this pump, located on Broad Street.

**bacteriological period of public health**  
the period of 1875–1900, during which the causes of many bacterial diseases were discovered

**health resources development period**  
the years of 1900–1960, a time of great growth in health care facilities and providers



**FIGURE 1.7**

Ellis Island immigration between 1860 and 1910 resulted in dramatic increases in the urban population in America.

paying jobs involving hard labor and low wages. There was also a deepening chasm between the upper and lower classes, and social critics began to clamor for reform.

The years 1900 to 1920 have been called the **reform phase of public health**. The plight of the immigrants working in the meat packing industry was graphically depicted by Upton Sinclair in his book *The Jungle*. Sinclair's goal was to draw attention to unsafe working conditions. What he achieved was greater governmental regulation of the food industry through the passage of the Pure Food and Drugs Act of 1906.

The reform movement was broad, involving both social and moral as well as health issues. Edward T. Devine noted in 1909 that "Ill health is perhaps the most constant of the attendants of poverty."<sup>30</sup> The reform movement finally took hold when it became evident to the majority that neither the discoveries of the causes of many communicable diseases nor the continuing advancement of industrial production could overcome continuing disease and poverty. Even by 1917, the United States ranked fourteenth of 16 "progressive" nations in maternal death rate.<sup>30</sup>

Although the relationship between occupation and disease had been pointed out 200 years earlier in Europe, occupational health in America in 1900 was an unknown quantity. However, in 1910 the first International Congress on Occupational Diseases was held in Chicago.<sup>31</sup> That same year, the state of New York passed a tentative Workman's Compensation Act, and over the next 10 years most other states passed similar laws.<sup>22</sup> Also in 1910, the U.S. Bureau of Mines was created and the first clinic for occupational diseases was established in New York at Cornell Medical College.<sup>30</sup> By 1910, the movement for healthier conditions in the workplace was well established.

**reform phase of public health**  
the years of 1900–1920,  
characterized by social movements to improve health conditions in cities and in the workplace

This period also saw the birth of the first national-level volunteer health agencies. The first of these agencies was the National Association for the Study and Prevention of Tuberculosis, which was formed in 1902. It arose from the first local voluntary health agency, the Pennsylvania Society for the Prevention of Tuberculosis, organized in 1892.<sup>32</sup> The American Cancer Society, Inc., was founded in 1913. That same year, the Rockefeller Foundation was established in New York. This philanthropic foundation has funded a great many public health projects, including work on hookworm and pellagra, and the development of a vaccine against yellow fever.

Another movement that began about this time was that of public health nursing. The first school nursing program was begun in New York City in 1902. In 1918, the first School of Public Health was established at Johns Hopkins University in Baltimore. This was followed by establishment of another school at Harvard University in 1923. Also in 1918 was the birth of school health instruction as we know it today.

These advances were matched with similar advances by governmental bodies. The Marine Hospital Service was renamed the Public Health and Marine Hospital Service in 1902 in keeping with its growing responsibilities. In 1912, it became the U.S. Public Health Service.<sup>25</sup>

By 1900, 38 states had state health departments. The rest followed during the first decades of the twentieth century. The first two local (county) health departments were established in 1911, one in Guilford County, North Carolina, and the other in Yakima County, Washington.

### *The 1920s*

In comparison with the preceding period, the 1920s represented a decade of slow growth in public health, except for a few health projects funded by the Rockefeller and Millbank foundations. Prohibition resulted in a decline in the number of alcoholics and alcohol-related deaths. Although the number of county health departments had risen to 467 by 1929, 77% of the rural population still lived in areas with no health services.<sup>32</sup> However, it was during this period in 1922 that the first professional preparation program for health educators was begun at Columbia University by Thomas D. Wood, MD, whom many consider the father of health education. The life expectancy in 1930 had risen to 59.7 years.

### *The Great Depression and World War II*

Until the Great Depression (1929–1935), individuals and families in need of social and medical services were dependent on friends and relatives, private charities, voluntary agencies, community chests, and churches. By 1933, after 3 years of economic depression, it became evident that private resources could never meet the needs of all the people who needed assistance. The drop in tax revenues during the Depression also reduced health department budgets and caused a virtual halt in the formation of new local health departments.<sup>32</sup>

Beginning in 1933, President Franklin D. Roosevelt created numerous agencies and programs for public works as part of his New Deal. Much of the money was used for public health, including the control of malaria, the building of hospitals and laboratories, and the construction of municipal water and sewer systems.

The Social Security Act of 1935 marked the beginning of the government's major involvement in social issues, including health. This act provided substantial support for state health departments and their programs, such as maternal and child health and sanitary facilities. As progress against the communicable diseases became visible, some turned their attention toward other health problems, such as cancer. The National Cancer Institute was formed in 1937.

America's involvement in World War II resulted in severe restrictions on resources available for public health programs. Immediately following the conclusion of the war, however, many of the medical discoveries made during wartime made their way into civilian medical practice. Two examples are the antibiotic penicillin, used for treating pneumonia, rheumatic

fever, syphilis, and strep throat, and the insecticide DDT, used for killing insects that transmit diseases.

During World War II, the Communicable Disease Center was established in Atlanta, Georgia. Now called the Centers for Disease Control and Prevention (CDC), it has become the premier epidemiological center of the world.

### *The Postwar Years*

Following the end of World War II, there was still concern about medical care and the adequacy of the facilities in which that care could be administered. In 1946, Congress passed the National Hospital Survey and Construction Act (the Hill-Burton Act). The goal of the legislation was to improve the distribution of medical care and to enhance the quality of hospitals. From 1946 through the 1960s, hospital construction occurred at a rapid rate with relatively little thought given to planning. Likewise, attempts to set national health priorities or to establish a national health agenda were virtually nonexistent.

The two major health events in the 1950s were the development of a vaccine to prevent polio and President Eisenhower's heart attack. The latter event helped America to focus on its number 1 killer, heart disease. When the president's physician suggested exercise, some Americans heeded his advice and began to exercise on a regular basis.

### *Period of Social Engineering (1960–1973)*

The 1960s marked the beginning of a period when the federal government once again became active in health matters. The primary reason for this involvement was the growing realization that many Americans were still not reaping any of the benefits of 60 years of medical advances. These Americans, most of whom were poor or elderly, either lived in underserved areas or simply could not afford to purchase medical services.

In 1965, Congress passed the Medicare and Medicaid bills (amendments to the Social Security Act of 1935). **Medicare** assists in the payment of medical bills for older adults and certain people with disabilities, and **Medicaid** assists in the payment of medical bills for the poor. These pieces of legislation helped provide medical care for millions who would not otherwise have received it, and this legislation also improved standards in health care facilities. Unfortunately, the influx of federal dollars accelerated the rate of increase in the cost of health care for everyone. As a result, the 1970s, 1980s, and the 1990s saw repeated attempts and failures to bring the growing costs of health care under control.

**Medicare**  
government health  
insurance for older  
adults and those with  
certain disabilities

**Medicaid**  
government health  
insurance for the poor

### *Period of Health Promotion (1974–Present)*

By the mid-1970s, it had become apparent that the greatest potential for saving lives and reducing health care costs in America was to be achieved through means other than health care.

Most scholars, policymakers, and practitioners in health promotion would pick 1974 as the turning point that marks the beginning of health promotion as a significant component of national health policy in the twentieth century. That year Canada published its landmark policy statement, *A New Perspective on the Health of Canadians*.<sup>33</sup> In [1976] the United States, Congress passed PL 94-317, the Health Information and Health Promotion Act, which created the Office of Health Information and Health Promotion, later renamed the Office of Disease Prevention and Health Promotion.<sup>34</sup>

In the late 1970s, the Centers for Disease Control conducted a study that examined premature deaths (defined then as deaths prior to age 65, but now as deaths prior to age 75) in the United States in 1977. That study revealed that approximately 48% of all premature deaths could be traced to one's lifestyle or health behavior—choices that people make. Lifestyles characterized by a lack of exercise, unhealthy diets, smoking, uncontrolled hypertension, and the inability to control stress were found to be contributing factors to premature mortality.<sup>35</sup> This led the way for the U.S. government's publication *Healthy People: The*

*Surgeon General's Report on Health Promotion and Disease Prevention*.<sup>36</sup> “This document brought together much of what was known about the relationship of personal behavior and health status. The document also presented a ‘personal responsibility’ model that provided Americans with the prescription for reducing their health risks and increasing their chances for good health.”<sup>37</sup>

*Healthy People* was then followed by the release of the first set of health goals and objectives for the nation, called *Promoting Health/Preventing Disease: Objectives for the Nation*.<sup>38</sup> At the time this edition of this book was going to press, the fourth edition of these goals and objectives, *Healthy People 2020*, was about to be released. Since their inception, these *Healthy People* documents have defined the nation’s health agenda and guided its health policy since their inception (see Box 1.3).

**BOX  
1.3**
**TIMELINE AND HIGHLIGHTS OF COMMUNITY AND PUBLIC HEALTH FROM 1700–2000**

- A. Eighteenth Century (1700s)**
1. Period characterized by industrial growth; workplaces were unsafe and unhealthy
  2. 1790: first U.S. census
  3. 1793: yellow fever epidemic in Philadelphia
  4. 1796: Dr. Edward Jenner successfully demonstrated smallpox vaccination
  5. 1798: Marine Hospital Service (forerunner to U.S. Public Health Service) was formed
  6. By 1799: several of America’s largest cities, including Boston, Philadelphia, New York, and Baltimore, had municipal boards of health
- B. First Half of Nineteenth Century (1800–1848)**
1. U.S. government’s approach to health was laissez faire
  2. 1813: first visiting nurse in United States
- C. Second Half of 19th Century (1848–1900)**
1. 1849, 1854: London cholera epidemics
  2. 1850: Modern era of public health begins
  3. 1850: Shattuck’s report
  4. 1854: Snow has pump handle removed from Broad Street pump
  5. 1863: Pasteur proposed germ theory
  6. 1872: American Public Health Association founded
  7. 1875–1900: Bacteriological period of public health
  8. 1876: Koch established relationship between a particular microbe and a particular disease
  9. 1900: Reed announced that yellow fever was transmitted by mosquitos
- D. Twentieth Century**
1. Health Resources Development Period (1900–1960)
    - a. The Reform Phase (1900–1920)
      - 1902: First national-level voluntary health agency created
      - 1906: Sinclair’s *The Jungle* published
      - 1910: First International Congress on Occupational Diseases
      - 1910: 45% of U.S. population was in the cities
      - 1911: First local health department established
      - 1913: American Cancer Society founded
      - 1917: United States ranked 14th of 16 in maternal death rate
      - 1918: Birth of school health instruction
      - 1918: First school of public health established in United States
  2. 1920s
    - a. 1922: Wood created first professional preparation program for health educators
    - b. 1930: Life expectancy in the United States was 59.7 years
  3. The Great Depression and WWII
    - a. 1933: New Deal; included unsuccessful attempt at national health care program
    - b. 1935: Social Security Act passed
    - c. 1937: National Cancer Institute formed
  4. Postwar Years
    - a. 1946: National Hospital Survey and Construction (Hill-Burton) Act passed
    - b. 1952: Development of polio vaccine
    - c. 1955: Eisenhower’s heart attack
- E. Period of Social Engineering (1960–1973)**
1. 1965: Medicare and Medicaid bills passed
- F. Period of Health Promotion (1974–present)**
1. 1974: Nixon’s unsuccessful attempt at national health care program
  2. 1974: *A New Perspective on the Health of Canadians* published
  3. 1976: Health Information and Health Promotion Act passed
  4. 1979: *Healthy People* published
  5. 1980: *Promoting Health/Preventing Disease: Objectives of the Nation* published
  6. 1990: *Healthy People 2000* published
  7. 1997: Clinton’s unsuccessful attempt at a national health care program
  8. 2000: *Healthy People 2010* published

### *Community Health in the Early 2000s*

Early in the new millennium, it is widely agreed that although decisions about health are an individual's responsibility to a significant degree, society has an obligation to provide an environment in which the achievement of good health is possible and encouraged. Furthermore, many recognize that certain segments of our population whose disease and death rates exceed the general population may require additional resources, including education, to achieve good health.

The American people face a number of serious public health problems. These problems include the continuing rise in health care costs, growing environmental concerns, the ever-present lifestyle diseases, emerging and reemerging communicable diseases, serious substance abuse problems, and disasters, both natural and humanmade. In the paragraphs that follow, we have elaborated on each of these problems briefly because they seem to represent a significant portion of the community health agenda for the years ahead.

### *Health Care Delivery*

In the previous edition of this book, in this section we wrote about the large number of Americans who were uninsured and the rising cost of health care and how these problems had detrimental effects on both the physical health of individuals and the economic health of the nation. In March 2010, significant changes were made to the U.S. health care system when President Barack Obama signed the Affordable Care Act (ACA) into law. Though the law has many components, the primary focus is to increase the number of Americans with health insurance (see Chapter 13 for a more in-depth discussion of the Affordable Health Care Act). The ACA does this, but by providing health insurance to an additional 32 million Americans, the costs will also go up, which will continue to make U.S. health care the most expensive in the world. In 2010, health expenditures were projected to be almost \$2.6 trillion, consume 17.3% of the gross domestic product (GDP), and are expected to reach \$4.5 trillion and 19.3% of the GDP by 2019.<sup>39</sup> America spends more per capita annually on health care (estimated at \$8,290 in 2010)<sup>39</sup> than any other nation. The cost of health care is an issue that still needs to be addressed.

### *Environmental Problems*

Millions of Americans live in communities where the air is unsafe to breathe, the water is unsafe to drink, or solid waste is disposed of improperly. With a few minor exceptions, the rate at which we pollute our environment continues to increase. Many Americans still believe that our natural resources are unlimited and that their individual contributions to the overall pollution are insignificant. In actuality, we must improve on our efforts in resource preservation and energy conservation if our children are to enjoy an environment as clean as ours. These environmental problems are compounded by the fact that the world population continues to grow; it is now more than 6.9 billion people and expected to reach 8 billion by the year 2026.<sup>40</sup>

### *Lifestyle Diseases*

The leading causes of death in the United States today are not the communicable diseases that were so feared 100 years ago but chronic illnesses resulting from unwise lifestyle choices. The prevalence of obesity and diseases like diabetes is increasing. The four leading causes of death in the early 2000s are heart disease, cancer, chronic lower respiratory diseases, and stroke.<sup>41</sup> Although it is true that everyone has to die from some cause sometime, too many Americans die prematurely because of their unhealthy lifestyles. In the latter part of the twentieth century, it was known that better control of behavioral risk factors alone—such as lack of exercise, poor diet, use of tobacco and drugs, and alcohol abuse—could prevent between 40% and 70% of all premature deaths, one-third of all acute disabilities, and

**Table 1.1**  
**Comparison of Most Common Causes of Death and Actual Causes of Death**

Most Common Causes of Death, United States, 2008	Actual Causes of Death, United States, 2000
1. Diseases of the heart	1. Tobacco
2. Malignant neoplasms (cancers)	2. Poor diet and physical inactivity
3. Chronic lower respiratory diseases	3. Alcohol consumption
4. Cerebrovascular diseases (stroke)	4. Microbial agents
5. Unintentional injuries (accidents)	5. Toxic agents
7. Alzheimer's disease	6. Motor vehicles
6. Diabetes mellitus	7. Firearms
8. Influenza and pneumonia	8. Sexual behavior
9. Nephritis, nephrotic syndrome, and nephrosis	9. Illicit drug use
10. Septicemia	

Sources: Miniño, A. M., J. Q. Xu, and K. D. Kochanek (2010). "Deaths: Preliminary Data for 2008." *National Vital Statistics Reports*, 59(2): Hyattsville, MD: National Center for Health Statistics; Mokdad, A. H., J. S. Marks, D. F. Stroup, and J. L. Gerberding (2004). "Actual Causes of Death, in the United States, 2000." *Journal of the American Medical Association*, 291(10): 1238–1245; and Mokdad, A. H., J. S. Marks, D. F. Stroup, and J. L. Gerberding (2005). "Correction: Actual Causes of Death, in the United States, 2000." *Journal of the American Medical Association*, 293(3): 293–294.

two-thirds of chronic disabilities.<sup>42</sup> Now into the twenty-first century, behavior patterns continue to "represent the single most prominent domain of influence over health prospects in the United States."<sup>9</sup> (See Table 1.1.)

### Communicable Diseases

Although communicable (infectious) diseases no longer constitute the leading causes of death in the United States, they remain a concern for several reasons. First, they are the primary reason for days missed at school or at work. The success in reducing the life-threatening nature of these diseases has made many Americans complacent about obtaining vaccinations or taking other precautions against contracting these diseases. With the exception of smallpox, none of these diseases has been eradicated, although several should have been, such as measles.

Second, as new communicable diseases continue to appear, old ones such as tuberculosis reemerge, sometimes in drug-resistant forms, demonstrating that communicable diseases still represent a serious community health problem in America. Legionnaires' disease, toxic shock syndrome, Lyme disease, acquired immunodeficiency syndrome (AIDS), and severe acute respiratory syndrome (SARS) are diseases that were unknown only 30 years ago. The first cases of AIDS were reported in June 1981.<sup>43</sup> By August 1989, 100,000 cases had been reported,<sup>44</sup> and it took only an additional two years to report the second 100,000 cases.<sup>45</sup> By 2006, more than a million cases of the disease had been reported to the CDC.<sup>46</sup> (See Figure 1.8.) The total number of cases continues to grow with close to 40,000 new cases being diagnosed each year.<sup>47</sup> Also, diseases that were once only found in animals are now crossing over to human populations and causing much concern and action. Included in



**FIGURE 1.8**

AIDS is one of the most feared communicable diseases today.

this group of diseases are avian flu, *Escherichia coli* O157:H7, hantavirus, mad cow disease, and SARS.<sup>1</sup>

Third, and maybe the most disturbing, is the use of communicable diseases for bioterrorism. **Bioterrorism** involves “the threatened or intentional release of biological agents (virus, bacteria, or their toxins) for the purpose of influencing the conduct of government or intimidating or coercing a civilian population to further political or social objectives. These agents can be released by way of the air (as aerosols) food, water or insects.”<sup>10</sup> Concern in the United States over bioterrorism was heightened after 9/11 and the subsequent intentional distribution of *Bacillus anthracis* spores through the U.S. postal system (the anthrax mailings). The anthrax mailings resulted in 22 people developing anthrax, 5 of whom died. In addition, thousands more were psychologically affected, and between 10 thousand and 20 thousand people were advised to take postexposure prophylactic treatment because they were at known or potential risk for inhalational anthrax.<sup>48</sup>

**bioterrorism**  
the threatened or intentional release of biological agents for the purpose of influencing the conduct of government or intimidating or coercing a civilian population to further political or social objectives

### *Alcohol and Other Drug Abuse*

“Abuse of legal and illegal drugs has become a national problem that costs this country thousands of lives and billions of dollars each year. Alcohol and other drugs are often associated with unintentional injuries, domestic violence, and violent crimes.”<sup>49</sup> Federal, state, and local governments as well as private agencies attempt to address the supply and demand problems associated with the abuse of alcohol and other drugs, but a significant challenge remains for America.

### *Health Disparities*

It has long been “recognized that some individuals are healthier than others and that some live longer than others do, and that often these differences are closely associated with social characteristics such as race, ethnicity, gender, location, and socioeconomic status.”<sup>50</sup> These gaps between groups have been referred to as *health disparities* (also call health inequalities in some countries). More formally, **health disparities** has been defined as the difference in health among different populations. Health disparities are a problem in the United States in that many minority groups’ health status, on many different measures, is not as good as the white population. Efforts have been put forth to eliminate the disparities, as evidenced by one of the *Healthy People 2020* overarching goals to “achieve health equity, eliminate disparities, and improve the health for all groups.” Many experts think these differences have been caused by two *health inequities*—lack of access to health care, and/or when health care is received the quality has not been as good for those in minority groups. Whatever the reason, health disparities continue to be a problem and much more needs to be done.

**health disparities**  
the difference in health among different populations

### *Disasters*

Disasters can be classified into two primary categories—natural (or conventional) and human-made (or technological disasters).<sup>1</sup> Whereas *natural disasters* are the result of the combination of the forces of nature (e.g., hurricane, flood, blizzard, tornado, earthquake, landslide) and human activities,<sup>51</sup> *humanmade disasters* result from either unintentional (e.g., spill of a toxic substance into the environment) or intentional (e.g., bioterrorism) human activities, often associated with the use or misuse of technology. Both types of disasters have the potential to cause injury, death, disease, and damage to property on a large scale.<sup>1</sup> In recent years, the United States has felt the large-scale impact of both types of disasters via the Gulf oil spill, Hurricanes Katrina and Rita, and the severe flooding in the middle of the country. All of these events showed us that the preparation for such disasters was not adequate and that each type of disaster required different resources and a different response.

Even though the causes of the two categories of disasters are different, preparedness for them has many common elements. It has been noted that preparedness for natural disasters

is the foundation for preparedness for humanmade disasters.<sup>52</sup> That is, in preparing for natural disasters, the basic components of an adequate disaster response system have been defined, and the steps necessary to build disaster preparedness capacity have been established.<sup>52</sup> What needs to be added are specific steps to deal with the peculiarity of the humanmade disasters. An example of this would be the need for decontamination following exposure to a biological agent.

Even given the devastating consequences of natural disasters, such as Hurricanes Katrina and Rita, flooding, or the forest fires that consume many thousands of acres of woodlands each year (see Chapter 14 for more on natural disasters), it has been the intentional humanmade disasters—specifically terrorism—that have occupied much of our attention in recent years (see Figure 1.9).

Mention was made earlier of the use of a communicable disease as part of terrorism. However, in fact a number of agents could be used as part of terrorism. Since the anthrax mailings, community and public health professionals have focused on the possibility that future terrorism could include chemical, nuclear/radiological, and/or biological (CNB) agents, resulting in mass numbers of casualties. Such concern led to an evaluation of community and public health emergency preparedness and response. “Determining the level of state and local health departments’ emergency preparedness and response capacities is crucial because public health officials are among those, along with firefighters, emergency medical personnel, and local law enforcement personnel, who serve on ‘rapid response’ teams when large-scale emergency situations arise.”<sup>13</sup> Results of that evaluation showed that the public health infrastructure was not where it should be to handle large-scale emergencies, as well as a number of more common public health concerns.

The . . . public health infrastructure has suffered from political neglect and from the pressure of political agendas and public opinion that frequently override empirical evidence. Under the glare of a national crisis, policy makers and the public became aware of vulnerable and outdated health information systems and technologies, an insufficient and inadequately trained public health workforce, antiquated laboratory capacity, a lack of real-time surveillance and epidemiological systems, ineffective and fragmented communications networks, incomplete domestic preparedness and emergency response capabilities, and communities without access to essential public health services.<sup>13</sup>

Based on the results of several different evaluations that exposed many weaknesses in emergency preparedness in general and in the public health infrastructure more specifically, investment in public health preparedness has increased since September 11, 2001. Those federal departments that have been responsible for most of the effort have been the Departments of Homeland Security (DHS) and Health and Human Services (DHHS). The DHS has the responsibility of protecting America, whereas the DHHS, has taken the leadership for public health and medical preparedness. **Public health preparedness** has been defined as “the ability of the *public health system, community, and individuals* to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those in which scale, timing, or unpredictability threatens to overwhelm routine capabilities,”<sup>53</sup> and **medical preparedness** has been defined as “the ability of the *health care system* to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing, or unpredictability threatens to overwhelm routine capabilities



**FIGURE 1.9**

Terrorism has become a concern throughout the world.

**public health preparedness**  
the ability of the *public health system, community, and individuals* to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those in which scale, timing, or unpredictability threatens to overwhelm routine capabilities

**medical preparedness**  
the ability of the *health care system* to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing, or unpredictability threatens to overwhelm routine capabilities

unpredictability threatens to overwhelm routine capabilities.”<sup>53</sup> Information about emergency preparedness and response can be found on the Web sites of all DHHS agencies; however, those that have been most visible have been the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), and the Agency for Healthcare Research and Quality (AHRQ).

Since 9/11, the federal government, through a variety of funding sources and programs, has worked to strengthen homeland security, emergency preparedness, and response at all levels. The funding has been used to create or enhance the various components needed in disaster situations (i.e., communication, coordination, and training for personnel). The funding also had to be used to bring much of the public health system up-to-date (i.e., laboratories, personnel, and surveillance) after many years of neglect.

Though the United States is better prepared than prior to 9/11, much still needs to be done. In December 2009, the Trust for America’s Health (TFAH), a nonprofit, nonpartisan organization, and the Robert Wood Johnson Foundation released their seventh report on the state of public health preparedness in the United States.<sup>54</sup> The report, titled *Ready or Not 2009?: Protecting the Public’s Health from Disease, Disasters, and Bioterrorism*, contained preparedness scores for all 50 states and the District of Columbia based on 10 key indicators to assess health emergency preparedness capabilities. Much of the seventh report focuses on the H1N1 flu outbreak the previous flu season. The indicators were developed in consultation with leading public health experts based on data from publicly available sources or information provided by public officials. “Twenty states scored six or less out of 10 key indicators of public health emergency preparedness. Nearly two-thirds of states scored seven or less. Eight states tied for the highest score of nine out of 10: Arkansas, Delaware, New York, North Carolina, North Dakota, Oklahoma, Texas, and Vermont. Montana had the lowest score at three out of 10.”<sup>54</sup> Some key findings from the report include the following:

- 27 states cut funding for public health from FY 2007–08 to 2008–09.
- 13 states have purchased less than 50 percent of their share of federally subsidized antiviral drugs to stockpile for use during an influenza pandemic.
- 14 states do not have the capacity in place to assure the timely pick-up and delivery of laboratory samples on a 24/7 basis to the Laboratory Response Network (LRN).
- 11 states and D.C. report not having enough laboratory staffing capacity to work five 12-hour days for six to eight weeks in response to an infectious disease outbreak, such as H1N1.<sup>54</sup>

Michelle Larkin, JD, Public Health Team Director and Senior Program Officer at the Robert Wood Johnson Foundation, commented on the report by saying, “State and local health departments around the country are being asked to do more with less during the H1N1 outbreak as budgets continue to be stretched beyond their limits. Public health provides essential prevention and preparedness services that help us lead healthier lives—without sustained and stable funding, Americans will continue to be needlessly at risk from the next public health threat.”<sup>55</sup>

## OUTLOOK FOR COMMUNITY HEALTH IN THE TWENTY-FIRST CENTURY

So far in this chapter we have discussed community health, past and present. Now we describe what community health leaders in the United States and elsewhere in the world hope to achieve in the coming years.

## World Planning for the Twenty-First Century

World health leaders recognized the need to plan for the twenty-first century at the thirtieth World Health Assembly of the World Health Organization, held in 1977. At that assembly, delegations from governments around the world set as a target “that the level of health to be attained by the turn of the century should be that which will permit all people to lead a socially and economically productive life.”<sup>56</sup> This target goal became known as “Health for All by the Year 2000.” The following year in Alma-Ata, U.S.S.R., the joint WHO/UNICEF (United Nations Children’s Fund) International Conference adopted a Declaration on Primary Health Care as the key to attaining the goal of Health for All by the Year 2000. At the thirty-fourth World Health Assembly in 1981, delegates from the member nations unanimously adopted a Global Strategy for Health for All by the Year 2000. That same year, the United Nations General Assembly endorsed the Global Strategy and urged other international organizations concerned with community health to collaborate with the WHO. The underlying concept of Health for All by the Year 2000 was that health resources should be distributed in such a way that essential health care services are accessible to everyone.

As we now know, the lofty goal of health for all around the world by the year 2000 was not reached. That does not mean that the goal was abandoned. With the passing into a new century, the program was renamed Health for All (HFA). HFA continues to seek “to create the conditions where people have, as a fundamental human right, the opportunity to reach and maintain the highest level of health. The vision of a renewed HFA policy builds on the WHO Constitution, the experience of the past and the needs for the future.”<sup>57</sup>

As one might expect with all of the unrest worldwide, the progress to HFA is slow. Yet, some progress has been made. Life expectancy has increased by between 6 and 7 years globally in the last 30 years, due primarily to (1) social and economic development, (2) the wider provision of safe water and sanitation facilities, and (3) the expansion of national health services.<sup>58</sup> However, all do not share in this increased life expectancy. “There are widening health inequities between and within countries, between rich and poor, between men and women, and between different ethnic groups. More than a billion of the world’s poorest people are not benefiting from the major advances in health care and several countries, particularly in sub-Saharan Africa, have seen a decline in life expectancy due in part to the HIV/AIDS epidemic.”<sup>58</sup>

The work and the related tasks that face the WHO are enormous. The widening health gap is fueled by the impact of communicable diseases, global increases in noncommunicable diseases (especially from tobacco use, unhealthy diets, physical inactivity, and alcohol abuse), and unintentional injuries (primarily from road traffic crashes). What makes the work even more difficult is that “WHO operates in an increasingly complex and rapidly changing landscape. The boundaries of public health action have become blurred, extending into other sectors that influence health opportunities and outcomes. WHO responds to these challenges using a six-point agenda. The six points address two health objectives, two strategic needs, and two operational approaches.”<sup>59</sup> These six points and a brief rationale for each are presented in Box 1.4.

As might be inferred from the stated priority areas in Box 1.4, much of the attention for improved world health in the twenty-first century is focused on the less developed and poorer countries of the world. The plan for tackling these global health challenges and other non-health-related global challenges of the twenty-first century is guided by the *United Nations Millennium Declaration*,<sup>60</sup> which was adopted at the United Nations’ Millennium Summit in September 2000. More information about the declaration is presented in Chapter 2 in the section that discusses the WHO.

BOX  
1.4

## THE WHO AGENDA

1. *Promoting development.* During the past decade, health has achieved unprecedented prominence as a key driver of socioeconomic progress, and more resources than ever are being invested in health. Yet poverty continues to contribute to poor health, and poor health anchors large populations in poverty. Health development is directed by the ethical principle of equity: Access to life-saving or health-promoting interventions should not be denied for unfair reasons, including those with economic or social roots. Commitment to this principle ensures that WHO activities aimed at health development give priority to health outcomes in poor, disadvantaged, or vulnerable groups. Attainment of the health-related Millennium Development Goals, preventing and treating chronic diseases and addressing the neglected tropical diseases, are the cornerstones of the health and development agenda.
2. *Fostering health security.* Shared vulnerability to health security threats demands collective action. One of the greatest threats to international health security arises from outbreaks of emerging and epidemic-prone diseases. Such outbreaks are occurring in increasing numbers, fueled by such factors as rapid urbanization, environmental mismanagement, the way food is produced and traded, and the way antibiotics are used and misused. The world's ability to defend itself collectively against outbreaks has been strengthened since June 2007, when the revised International Health Regulations came into force.
3. *Strengthening health systems.* For health improvement to operate as a poverty-reduction strategy, health services must reach poor and underserved populations. Health systems in many parts of the

world are unable to do so, making the strengthening of health systems a high priority for WHO. Areas being addressed include the provision of adequate numbers of appropriately trained staff, sufficient financing, suitable systems for collecting vital statistics, and access to appropriate technology including essential drugs.

4. *Harnessing research, information, and evidence.* Evidence provides the foundation for setting priorities, defining strategies, and measuring results. WHO generates authoritative health information, in consultation with leading experts, to set norms and standards, articulate evidence-based policy options, and monitor the evolving global health situation.
5. *Enhancing partnerships.* WHO carries out its work with the support and collaboration of many partners, including UN agencies and other international organizations, donors, civil society, and the private sector. WHO uses the strategic power of evidence to encourage partners implementing programs within countries to align their activities with best technical guidelines and practices, as well as with the priorities established by countries.
6. *Improving performance.* WHO participates in ongoing reforms aimed at improving its efficiency and effectiveness, both at the international level and within countries. WHO aims to ensure that its strongest asset—its staff—works in an environment that is motivating and rewarding. WHO plans its budget and activities through results-based management, with clear expected results to measure performance at country, regional and international levels.

Source: Reprinted with permission of World Health Organization (2010). "The WHO Agenda." Available at <http://www.who.int/about/agenda/en/index.html>. Accessed October 28, 2010.

### The United States' Planning for the Twenty-First Century

In addition to its participation in WHO's plans for the twenty-first century, the United States has created its own plans. The United States has decided to develop its planning process around 10-year blocks of time. The current plan is called *Healthy People 2020*.<sup>61</sup> As noted earlier in this chapter, *Healthy People 2020* and its three predecessor editions do in fact outline the health agenda of the nation. Some have referred to the *Healthy People* documents as the health blueprint of the nation. Each of these documents obviously is created on the best available data at the time, but all have been structured in a similar way. All four editions include several overarching goals and many supporting objectives for the nation's health. The goals provide a general focus and direction, while the objectives are used to measure progress within a specified period of time. Formal reviews (i.e., measured progress) of these

objectives are conducted both at midcourse (i.e., halfway through the 10-year period) and again at the end of 10 years. The midcourse review provides an opportunity to update the document based on the events of the first half of the decade for which the objectives are written. For example, in *Healthy People 2010*, a number of objectives were changed, updated, or deleted because of the events of 9/11 and Hurricanes Katrina and Rita. Both the results of the midcourse and end reviews along with other available data are used to help create the next set of goals and objectives.

*Healthy People 2020*, which was released in December 2010, includes a vision statement, a mission statement, four overarching goals (see Table 1.2), and many objectives spread over 42 different topic areas (see Table 1.3). On the Healthy People.gov Web site each topic has its own Web page. At a minimum each page contains a concise goal statement, a brief overview of the topic that provides the background and context for the topic, a statement about the importance of the topic backed up by appropriate evidence, and references. There are two types of objectives—measurable and developmental. The measurable objectives provide direction for action and include national baseline data from which the 2020 target was set. The developmental objectives provide a vision for a desired outcome or health status, but national baseline data were not available when they were written. The purpose of developmental objectives is to identify areas of emerging importance and to drive the development of data systems to measure them.

The developers of *Healthy People 2020* think that the best way to implement the national objectives is with the framework referred to as MAP-IT (see Figure 1.10). MAP-IT stands for Mobilize, Assess, Plan, Implement, and Track. The Mobilize step of MAP-IT deals with bringing interested parties together within communities to deal with health issues. The second step, Assess, is used to find out who is affected by the health problem and examine what resources are available to deal with the problem. In the Plan step, goals and objectives are created and an intervention is planned that has the best chances of dealing with the health problem. The Implement step deals with putting the intervention into action. And the final step, Track, deals with evaluating the impact of the intervention on the health problem.<sup>61</sup>

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**Table 1.2**  
**Healthy People 2020 Vision, Mission, and Goals**

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**Vision**

A society in which all people live long, healthy lives.

**Mission**

*Healthy People 2020 strives to:*

- Identify nationwide health improvement priorities
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress
- Provide measurable objectives and goals that are applicable at the national, state, and local levels
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge
- Identify critical research, evaluation, and data collection needs

**Overarching Goals**

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

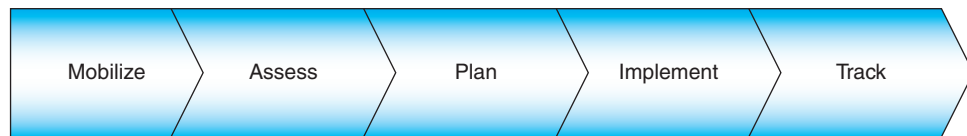
*Source:* U.S. Department of Health and Human Services (2010). *About Healthy People*. Available at <http://www.healthypeople.gov/2020/about/default.aspx>. Accessed December 13, 2010.

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**Table 1.3**  
**Healthy People 2020 Topic Areas**

1. Access to Health Services	21. Heart Disease and Stroke
2. Adolescent Health	22. HIV
3. Arthritis, Osteoporosis, and Chronic Back Conditions	23. Immunization and Infectious Diseases
4. Blood Disorders and Blood Safety	24. Injury and Violence Prevention
5. Cancer	25. Lesbian, Gay, Bisexual, and Transgender Health
6. Chronic Kidney Disease	26. Maternal, Infant, and Child Health
7. Dementias, Including Alzheimer’s Disease	27. Medical Product Safety
8. Diabetes	28. Mental Health and Mental Disorders
9. Disability and Health	29. Nutrition and Weight Status
10. Early and Middle Childhood	30. Occupational Safety and Health
11. Educational and Community-Based Programs	31. Older Adults
12. Environmental Health	32. Oral Health
13. Family Planning	33. Physical Activity
14. Food Safety	34. Preparedness
15. Genomics	35. Public Health Infrastructure
16. Global Health	36. Respiratory Diseases
17. Healthcare-Associated Infections	37. Sexually Transmitted Diseases
18. Health Communication and Health Information Technology	38. Sleep Health
19. Health-Related Quality of Life and Well-Being	39. Social Determinants of Health
20. Hearing and Other Sensory or Communication Disorders	40. Substance Abuse
	41. Tobacco Use
	42. Vision

Source: U.S. Department of Health and Human Services (2010). *Topics & Objectives Index—Healthy People*. Available at <http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx>. Accessed December 13, 2010.



**FIGURE 1.10**  
The Action Model to Achieve Healthy People Goals

Source: U.S. Department of Health and Human Services (2010). *Implementing Healthy People 2020*. Available at <http://www.healthypeople.gov/2020/implementing/default.aspx>. Accessed December 16, 2010.

As can be seen in the material presented in the last few pages, both the World Health Organization and the U.S. Department of Health and Human Services have much work ahead to improve the health of the people of the world and the United States in the twenty-first century. Because the planning to improve health is always changing, we urge all students of community and public health to stay up-to-date by regularly visiting both the World Health Organization and *Healthy People 2020* Web sites.

## CHAPTER SUMMARY

- A number of key terms are associated with the study of community health, including *health*, *community*, *community health*, *population health*, *public health*, *public health system*, and *global health*.
- The four factors that affect the health of a community are physical (e.g., community size), social and cultural (e.g., religion), community organization, and individual behaviors (e.g., exercise and diet).
- It is important to be familiar with and understand the history of community health to be able to deal with the present and future community health issues.
- The earliest community health practices went unrecorded; however, archeological findings of ancient societies (before 500 B.C.) show evidence of concern for community health. There is evidence during the time of the classical cultures (500 B.C.–A.D. 500) that people were interested in physical strength, medicine, and sanitation.
- The belief of many living during the Middle Ages (A.D. 500–1500) was that health and disease were associated with spirituality. Many epidemics were seen during this period.
- During the Renaissance period (A.D. 1500–1700), there was a growing belief that disease was caused by the environment, not spiritual factors.
- The eighteenth century was characterized by industrial growth. Science was being used more in medicine and it was during this century that the first vaccine was discovered.
- The nineteenth century ushered in the modern era of public health. The germ theory was introduced during this time, and the last fourth of the century is known as the bacteriological period of public health.
- The twentieth century can be divided into several periods. The health resources development period (1900–1960) was a time when many public and private resources were used to improve health. The period of social engineering (1960–1973) saw the U.S. government's involvement in health insurance through Medicare and Medicaid. The health promotion period began in 1974 and continues today.
- Great concern still exists for health care, the environment, diseases caused by an impoverished lifestyle, the spread of communicable diseases (such as AIDS, Legionnaires' disease, toxic shock syndrome, and Lyme disease), the harm caused by alcohol and other drug abuse, and terrorism.
- Both the WHO and the U.S. government continue to plan for the health of humanity. The planning of the United States is reflected in the *Healthy People* documents, the health agenda for the nation.

## SCENARIO: ANALYSIS AND RESPONSE

The Internet has many sources of information that could help Amy and Eric with the decisions that they will have to make about the continued use of the day care center for their children. Use a search engine (e.g., Google, Bing) and enter (a) hepatitis, and (b) hepatitis and day care centers. Print out the information that you find and use it in answering the following questions.

1. Based on the information you found on the Web, if you were Amy or Eric would you take your children to the day care center the next day? Why or why not?
2. Do you feel the hepatitis problem in day care centers is a personal health concern or a community health concern? Why?
3. Which of the factors noted in this chapter that affect the health of a community play a part in the hepatitis problem faced by Amy and Eric?
4. Why does the hepatitis problem remind us of the health problems faced by people in this country prior to 1900?
5. Under which of the focus areas in the *Healthy People 2020* would hepatitis fall? Why?

## REVIEW QUESTIONS

1. How did the WHO define health in 1946? How has that definition been modified?
2. What is public health?
3. What are the differences among community health, population health, and global health?
4. What are the five major domains that determine a person's health?
5. What is the difference between personal health activities and community health activities?
6. Define the term *community*.
7. What are four major factors that affect the health of a community? Provide an example of each.
8. Identify some of the major events of community health in each of the following periods of time:
  - Early civilizations (prior to A.D. 500)
  - Middle Ages (A.D. 500–1500)
  - Renaissance and Exploration (A.D. 1500–1700)
  - The eighteenth century
  - The nineteenth century
9. Provide a brief explanation of the origins from which the following twentieth-century periods get their names:
  - Health resources development period
  - Period of social engineering
  - Period of health promotion
10. What are the major community health problems facing the United States in the twenty-first century?
11. What is included in the World Health Organization's Agenda?
12. What significance do the *Healthy People* documents have in community health development in recent years?
13. What significance do you think *Healthy People 2020* will have in the years ahead?

## ACTIVITIES

1. Write your own definition for *health*.
2. In a two-page paper, explain how the five major determinants of health could interact to cause a disease such as cancer.
3. In a one-page paper, explain why heart disease can be both a personal health problem and a community health problem.
4. Select a community health problem that exists in your hometown; then, using the factors that affect the health of a community noted in this chapter, analyze and

discuss in a two-page paper at least three factors that contribute to the problem in your hometown.

5. Select one of the following individuals (all have been identified in this chapter), go to the library and do some additional reading or find two reliable Web sites, and then write a two-page paper on the person's contribution to community health.

Edward Jenner  
John Snow  
Lemuel Shattuck  
Louis Pasteur  
Robert Koch  
Walter Reed

6. Review a copy of *Healthy People 2020* on the Web. Then, set up a time to talk with an administrator in your hometown health department. Find out which of the objectives the health department has been working on as priorities. Summarize in a paper what the objectives are, what the health department is doing about them, and what it hopes to accomplish by the year 2020.

## COMMUNITY HEALTH ON THE WEB



The Internet contains a wealth of information about community and public health. Increase your knowledge of some of the topics presented in this chapter by accessing the Jones & Bartlett Learning Web site at <http://health.jbpub.com/book/communityhealth/7e> and follow the links to complete the following Web activities.

- *Healthy People 2020*
- Department of Homeland Security
- Global Health

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