COMMENTARY

The voice of the public in public health policy and planning: The role of public judgement

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SCUTCHFIELD, Ireson and Hall's timely arguments can open an important dialogue that I believe is long overdue, and which I hope will continue and bring some reality to the concepts of 'community' and 'community health planning'.

I should probably begin this commentary by informing the reader that my comments are probably colored by the fact that I have spent my entire 44 years of public health and public medical care management in the four largest public health and public medical care venues in the nation: New York City, Chicago, Houston and Los Angeles County. The term 'community' has, therefore, always been a troublesome one for me. The questions are really simple in venues such as these:

- How do you define 'community' in a city of 7 million people or a county of almost 10 million?
- How do you lead dozens and in some cases hundreds of stakeholders with their own narrow health agendas to come to 'public judgment' on any single public health issue?
- How do you plan for addressing public health problems that are:
  1. the result of human behavior;
  2. encountered in a budgetary context that is annual rather long term;
  3. and in a programmatic context that may change with the next local or State or national election;
  4. when the budgetary and programmatic decisions are being driven by those political realities?

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We need not look very far back in history to assess the reality of these questions. Who among us in public health leadership positions would have predicted five years ago or even three years ago that the federal government would be pouring dollars into State and local venues to reconstruct neglected public health infrastructure because of the fear of bioterrorism? But the reality is that in the 'community' where I work, a teenager leaving home for school on any morning or a three-year-old playing in the front yard of her home on any day is more at risk of dying of a stray bullet to the brain than from any of the bacteria or viruses that a determined terrorist could weaponize to terrorize my 'community.' How do you bring a 'community' to 'public judgment' on public health priorities when their perception of their public health risk is so discordant with that of the national political health agenda?

It is worthy of note that in the experience described in the Owensboro, Kentucky case study, after an 11-month process, “there were two major themes that resulted from data collection and analysis, health behavior and access/cost/quality issues. The former was seen as largely the purview of the health department and the major deliberation was focused on the latter.” This statement suggests that 'health behavior' was seen as largely the purview of the health department because health departments have been singularly effective in positively affecting health behaviors. I would submit that our greatest successes in changing human behavior have been when we could influence public policy and thus change community norms by the passage of effective legislation. Those public policy initiatives required much more community involvement to influence legislators than any deliberations regarding access/cost/quality issues.

A case in point is the legislative initiatives which have made cigarette smoking unacceptable in the workplace by giving non-smokers the right to demand a smoke-free work environment, made it illegal to market tobacco products to children and tax the products to put them beyond the financial reach of children and many teenagers.

Further, communities do not define themselves in the way that public health agencies do. In a recent experience in Los Angeles county, the County public health agency was asked by a foundation initiative to partner with five community organizations to carry out projects in a program called “Partnerships For the Public’s Health.” The public health agency had no part in defining or designing these projects. The