“The Scope of Public Health”

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I want to thank Genesee County Health Officer Bobby Pestronk and the Genesee County Board of Health for this kind invitation to return to Michigan and to Genesee County. It is a great pleasure to be here with all of you and with Mr. Hammon, Mr. Hammel, and Senator Emerson. I want to say, right at the beginning, that the Centers for Disease Control and Prevention has keen recognition of the critical role that state and local elected officials and members of boards of health play in protecting the health of Americans.

Michigan is well known for leadership in public health and for a number of public health “firsts”. I want to mention three important examples that span a 60-year history.

The first is the historic leadership that the city of Grand Rapids exhibited in 1945 when it became the first municipality in the United States to fluoridate its public drinking water. The second is Michigan’s national leadership in setting standards for public health agencies and in achieving accreditation for every local public health department in the state. And the third is the Genesee Health Plan, an innovative, non-profit corporation that is opening access for health to 22,000 low-income adults.

Michigan is widely respected also for your excellent county health departments, for the dynamic Michigan Association of Local Public Health, and for being the home of one of the nation’s top schools of public health.

This is the first of an ongoing series of annual conferences where Genesee County will put the spotlight on health and wellbeing, on innovative approaches to advancing the public’s health that come from the community itself, and on the contribution that improved health makes to economic growth and family wellbeing.

My central point today is very simple, that is, that “scope determines success.” Because this is the inaugural Genesee County public health forum, it seems fitting to spend the next few minutes exploring the scope of public health today, what our vision is for the scope of public health tomorrow, and what we will do to achieve that vision.

To set the stage, I'd like to sketch out some of the major features of the public health landscape—some of the leading challenges to the health of Americans, and powerful factors that are shaping the environment in which public health professionals, policy makers, and partners work.

Health Challenges

Let me start with a quick outline of some of the health challenges we face. When our remarkable CDC director Dr. Julie Gerberding testified in the U.S. Senate just three weeks ago, she told the Senators that the United States faces two types of public health challenges. She called one of them "urgent threats" and the other one "urgent realities." The "urgent threats" are the headline grabbers: bioterrorism, killer hurricanes and other natural disasters, and influenza pandemics, mention just a few. None of these, sadly enough, is hypothetical. As my colleague and good friend Jane Speakman will remind us when she speaks later this morning, SARS killed 774 people internationally in 2003 and cost our neighbors in Toronto and Ontario hundreds of millions of dollars in economic losses in the span of just a few weeks. One scenario for pandemic influenza—and by no means the most extreme one—projects that it could kill some 2 million Americans, sicken 90 million, and cause massive disruption in our economy and society.

The "urgent realities" Dr. Gerberding referred to are the diseases and other health threats that stem from factors that account for the vast majority of illnesses, disabilities, and deaths day in and day out. You know what these are—hearth disease, cancer, emphysema and other diseases of the lungs, unintentional injuries (which are the leading cause of death for all ages between 1 and 34 years of age), diabetes, influenza and pneumonia, Alzheimer's disease, and diseases of the liver.

The underlying, major causes of these "urgent realities" also are well known: tobacco, unhealthy eating habits, physical inactivity, alcohol and drug abuse, seasonal influenza and pneumonia, toxic agents (such as particulates associated with air pollution, environmental tobacco smoke, and other indoor air pollution), motor vehicle crashes, firearms, and sexual behavior (HIV, hepatitis B and C, and cervical cancer). They affect all communities but, as we all know, they impose special burdens on the poor and on minorities, fueling the health disparities that we all should pledge to erase.

The good news is that much of the burden can be prevented. We know this from the truly astonishing public health successes of the 20th century and also because we are gaining powerful new knowledge and tools virtually on a daily basis.

It's worth reflecting on the "great public health achievements" of the 20th century for a moment because they show how far we have come—and how much we can achieve when we define the scope of public health broadly. Here is just one example. In the early 20th century, infectious diseases were far away the leading causes of death for Americans. The "big three" were pneumonia, tuberculosis, and diarrhea and enteritis. Together with diphtheria, they caused one-third of all deaths. Smallpox, paralytic poliomyelitis, and measles also were commonplace as well. But by the end of the century smallpox had

been eradicated from the globe and diphtheria, paralytic poliomyelitis, and measles were totally eliminated from the United States. The prevalence of pertussis, mumps, rubella, and *Haemophilus influenzae* type b fell by more than 95%. And pneumonia, tuberculosis, and diarrhea/enteritis were greatly reduced. Today, chronic diseases are the overwhelming cause of premature death.

Neither of the "urgents" Dr. Gerberding testified about is more important than the other. Obviously, we must prepare for the "urgent threats" at the very same time that we intensify our attack on the "urgent realities." In fact, preparing for "urgent threats"—such as pandemic influenza—is going to give us greater ability to address the phenomena of seasonal, annual influenza that kills an estimated 36,000 Americans each year and hospitalizes 200,000. This will happen because we will develop better disease detection systems and reporting systems, faster vaccine production capacity, better coordination between public health departments and health care providers, and updated laws to authorize these activities.

The 20th-century progress in fighting infectious diseases is especially educational for us here today because it was achieved not by medicine alone, nor by public health departments alone, but, instead, by the concerted work of a broad and cross-cutting spectrum of partners. Of course, they included scientists who developed vaccines, diagnostic techniques, and medical treatments for those stricken by infectious disease. But they also included front-line epidemiologists, sanitarians, public health nurses and, very importantly, engineers and staff of public drinking water systems, housing departments that enforced zoning codes to reduce tenement crowding, the elected officials who authorized public powers, attorneys who guided their use, and state and municipal judges who enforced them while simultaneously protecting individual and property rights.

Giving a broad definition to the scope of who can influence the health of the American public was critical to the 20th-century public health achievements. And it is even more important today.

<u>Change Drivers</u>

Another part of our landscape is framed by macro-forces that are transforming the world we live in, that are creating new tools we can use to fight for better health, and that are simultaneously boosting expectations for public health agencies at all levels. Let me just mention a few of these:

-- In the area of scientific and technological developments:

Vaccines revolutionized public health in the 19th and 20th centuries. New vaccines are coming out, almost literally as we speak, and hold great promise for infectious disease control, especially in children and adolescents. The FDA approved a new oral vaccine for rotavirus on Feb. 3 and the Advisory Committee on Immunization Practices has

recommended it for virtually all infants. Rotavirus is one of the most common causes of intestinal disease and severe diarrhea among infants.

New testing technologies are in our hands. New, rapid, self-administered tests for HIV infection help reduce the number of people who are ignorant of their HIV status, encouraging them to get into treatment, helping prevent progression to AIDS, and helping prevent HIV transmission to others.

Separately, CDC is using state-of-the-art biomonitoring technology to measure the presence of 148 chemicals in Americans' bodies. This new ability to measure the actual "body burden" of these substances—many for the very first time—is helping establish baseline measures against which we will be able to observe long-term trends. Biomonitoring already is giving us immensely valuable information. Cotinine is a chemical the body produces from nicotine and only from nicotine. Biomonitoring tests repeated over a number of years demonstrate that the level of cotinine in the bodies of American children has been declining and this, in turn, is one basis for concluding that clean indoor aid ordinances are effective in reducing nonsmokers' exposure to tobacco smoke.

Population genomics is yet another promising, scientific area that will help us better understand genetic susceptibility to chronic disease and to design programs to inform at-risk family members and larger populations about steps they can take to help prevent the onset of disease.

-- In the area of economic and social developments:

It's no secret that the United States is experiencing far-reaching economic and social changes. Clearly, globalization is redefining what it takes for a company and a nation, to compete successfully in the international market. This is making Americans rethink how we do business and what we can do to remain competitive.

Can businesses compete in the face of increasingly expensive employee health care plans? Can small firms remain in business afford to offer any health benefits? If not, will the Genesee County Health Department, and other county and city health departments be expected to fill the resulting gaps in health care?

Can we as a nation afford to devote the highest percentage of Gross Domestic Product—of any country in the world—to therapeutic or curative health care or should we heed the call issued by the Michigan State Medical Society for physicians who now on average "spend 95 percent of their time treating illnesses" to cut that care to just 25 percent of their time and to boost prevention and health promotion to 75 percent?

How can public health agencies work with health care providers to achieve that true paradigm shift—which is something we have argued for decades? Shouldn't we take part in creating truly integrated information systems that give every health care provider access to wholistic information on individual patients but that also give them tools

custom tailored for prevention: for example, constantly updated, real-time information on health conditions and trends in the patient's community, as well as updated guidelines for encouraging patients to practice prevention in their own lives.

Here is another, very different, change driver…one that is creating a dramatic new opportunity for public health. This is the emergence of the "health-smart" society where the Internet, health care providers, and the mass media are giving people unprecedented access to information they can use to make health decisions for themselves and their families. The advent of the "health-smart" society is creating important new channels for communicating prevention information directly to Americans. To a significant extent, what actually is happening is a shift from the traditional "supply-side" model in which public health professionals work hard to communicate health information we believe is important to a public that may or may not be receptive to a radically different "demand-side" model where growing numbers of Americans actively seek out information they can use to address their self-defined health concerns and goals.

Many public health agencies are taking advantage of this remarkable opportunity, posting user-friendly prevention information on their websites, and by offering the same information on demand through 1-800 phone numbers and other media. CDC is constantly enriching the consumer-oriented health information on its website and is supplementing it with health information for health care providers. I know that Michigan is doing something very similar and that Michigan also is giving public health an appealing, statewide "face" or brand through the "For Michigan, For You" campaign.

The last "change drivers" to mention are twins: the high expectations citizens and their elected representatives hold for public health agencies as government agencies—coupled with what appears to be a chronically constrained financial situation. Neither of these is new and it does not seem likely that either will go away in the foreseeable future. Performance and accountability have been watchwords for government starting as early as the 1980s and progressing with enactment of the Government Performance and Results Act of 1993, the runaway success of the book "Reinventing Government" a couple of years later, and development of a culture in which elected officials properly emphasize results and health impact.

In summary, these and other powerful change factors or "change drivers" are transforming the environment in which we operate, raising expectations for public health agencies, and also giving us valuable new tools and resources we can use to address public health challenges. The challenge these "change drivers" pose for CDC and for state and local public health agencies is to set goals and priorities, to innovate, to demonstrate accountability, and to expand the scope of the public health system through partnerships.

Now I want to focus on the remarkable public health transformation we see taking place across the country.

How CDC Is Transforming Itself

I have deliberately said little about CDC so far because CDC gets so much media attention that the public may begin to think that CDC is the entirety of the nation's public health system. Nothing could be further from the truth. As you know, CDC is an important part—but only one part—of that system.

CDC is the lead federal public health agency. We monitor the nation's health, send disease detectives to investigate outbreaks, conduct prevention research, operate sophisticated, send about 75% of the $8 billion budget Congress gives us to state and local public health agencies, partner organizations, and researchers, and at any given time have several hundred professional staff stationed in state and local health departments and in international locations as well. CDC works in all the fields of public health—chronic and infectious disease, environmental and occupational health, injury, birth defects and developmental disabilities, public health genomics, and others as well.

CDC was established in 1946 and has grown over the years, partly in response to convulsive health threats such as HIV/AIDS in the 1980s, anthrax bioterrorism in 2001, and SARS in 2003. We added program on program, sometimes as mandated by Congress, but ultimately found that CDC had become a collection of disconnected "silo" or "stovepipe" activities. We hadn't aligned our resources with the major causes of premature disease and death, we weren't coordinating programs for maximum impact, we found it difficult to demonstrate accountability, and, very important, we were not creating alliances with new partners who could bring new perspectives and resources to bear.

Two years ago, CDC embarked on its "Futures Initiative", rethinking what we were doing, and how we were doing it, from the ground up. That process now is almost 100 percent complete and it is clear that one of the most important things we did was to identify a set of 24 "Health Protection Goals" for the agency.

The Health Protection Goals are rapidly becoming the guiding framework for what CDC does. CDC is in the process of aligning its priorities, programs, budget, staff, grants, and research—our entire portfolio—with the Goals. We're putting performance measures and tracking systems in place to make sure we reach the goals and to demonstrate accountability to Washington, to our partners, and to the American public.

We're also changing how we do our work. Partnerships have always been critical to CDC and to the entire public health system. From the very beginning, CDC has worked with county, city, state, and tribal health colleagues and their professional organizations. Some of the best known of the latter are the National Association of County and City Health Officials (where Bobby is currently Vice President), the Association of State and Territorial Health Officials, the counterpart associations of public health epidemiologists and laboratory directors and, of course, the American Public Health Association. Health care provider organizations have been traditional partners as well.

Beginning in the 1990s, if not earlier, CDC has greatly expanded the scope of its partnerships. Today they include, among many others:

- Elected and appointed policy makers—such as the National Association of Local Boards of Health, the National Conference of State Legislatures, and the National Governors Association

- Community-based and faith-based organizations

- The American Bar Association and the American Health Lawyers Association

- Emergency response and law enforcement organizations such as the National Emergency Management Association and the International Association of Chiefs of Police, and

- The American Planning Association and the American Institute of Architects.

CDC's recognition of the value of partnering—and of expanding the scope of public health become so compelling that we have created a new center—the National Center for Health Marketing—charged to strengthen existing partnerships and to create new ones, all of which are focused on the Health Protection Goals.

Transformation in Local and State Public Health

In 1932, U.S. Supreme Court Justice Louis D. Brandeis wrote that "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."

Justice Brandeis' observation is directly relevant to the grass-roots transformation that is taking place throughout public health today. It is literally impossible to capture, or even list, all the public health innovations being generated in communities and states but a few illustrations from the realm of "urgent realities" will make the point.

I'm thinking, for example, about the cities, counties, states, health care providers, and nonprofit groups of many different kinds who organize comprehensive tobacco control initiatives that teach young people about the dangers of tobacco, secure passage of clean indoor air laws and tobacco excise tax increases, staff "quit lines", and build counseling into health care benefit plans.

In Union County, Ohio, the health department is collaborating with the Honda car plant in a tobacco cessation program where the rate of smoking is unusually high.

I'm thinking of similar efforts to address youth obesity through more nutritious school meals, restrictions on in-school access to soft drinks, reinstitution of physical education in schools, initiatives that address both healthy nutrition and physical activity (like the "Eat Well-Play Hard" program in Elyria, Ohio), and reporting BMI test results to parents of school children (as is being done in Arkansas).

County health departments are leading initiatives to make neighborhoods more conducive to walking and bicycling, and to steer land use policies in "smart growth" and "healthy growth" directions—a nationally known innovator in this area is the Ingham County Land Use and Health Team.

State health departments in Indiana, Kentucky, Arkansas, and Arizona are pushing the envelope by working with the courts to develop public health "bench books" that judges can use for quick background on the relevant laws when a local health official requests an injunction against a persistent polluter or when someone who is subject to a quarantine order challenges the health department's authority to issue it.

In light of the escalating diabetes epidemic, the New York City health department recently adopted a regulation that requires 120 medical testing laboratories to report the result of A1c blood tests within 2 hours—that's a test to monitor diabetics' success in controlling their condition. This is first time, I know of, any government has required routine reporting of laboratory test results for a major chronic, noninfectious disease so that government officials can scrutinize how well doctors and patients are treating it.

In Pinnellas County, Florida (the Tampa area) the county health department innovated the "Jail Linkage Program" in which inmates are offered testing, consultation, and education related to STDs, HIV, hepatitis, and other infectious diseases that can circulate from the community to the jails and back again.

Another example of the dynamic transformation underway in public health is one you know very well—the Genesee Health Plan. The Plan is a remarkable innovation to expand health care access for low-income adults. Within that mission it also speaks to the "urgent health realities" through its disease management program that focuses on diabetes and heart disease. And the Plan's new program for small business employees is a direct response to the challenge that steadily escalating health care costs pose for small employers. You deserve a great deal of credit for this innovation and you may be sure that it will be looked to as a model by other communities across the country.

Community and state public health leaders—and their partners—are not limiting their creativity to designing new prevention programs and services, as important as these are. Meeting our health goals hinges on having a complete system in place to monitor health conditions, and develop and implement those services. But how do we know when we have "a system" in place and how do we know when it is working well? How can a county commission, a city council, or a state legislature be confident that an effective health protection system is in place for Genesee County, for Charlotte, North Carolina, or for the state of Washington?

Well, just a few years ago there really was no way to answer these questions. We didn't have an accepted definition of an effective local health department, we didn't have a clear idea of what a local or state public health system is, and we didn't have practical standards of performance for them.

The situation is dramatically improved today. Starting just a few years ago, local and state public health leaders took the initiative to address every one of those gaps. Today the National Association of County and City Health Officials has published an "Operational Definition of an Effective Health Department," the National Public Health Performance Standards Program has the scope of public health systems at the community and state levels broadly to include many private- and public-sector partners, and that Program has published detailed checklists that members of local and state public health systems are using to assess the capacity and performance of their public health departments and systems. Many of you are familiar with these checklists and know that they put great emphasis on defining the scope of public health broadly to include both traditional and novel partners.

And there is even more. All this work is moving very purposively in the direction of the accreditation of public health departments—as pioneered in Michigan, North Carolina, and Washington, among other states. Later this summer a national task force of public health leaders will publish a blueprint for a voluntary public health accreditation system that will accelerate adoption of accreditation in still more states.

When Department of Health and Human Services Secretary Mike Leavitt visited CDC in March of this year, he commented that "The 21st century is the century of standards." Accreditation is all about standards as a way to strengthen our public health system and about accounting to the public and to elected leaders for our use of the resources they endow us with—one of the most powerful "change drivers" of our time.

Justice Brandeis would be proud of every one of these innovations created in the laboratory of front-line public health practice. They have many features in common but the one that is so illuminating for us today is that all of them are the children of partnerships deliberately formed by local or state health departments—with elected officials (e.g., the Genesee County Board of Commissioners), philanthropic foundations, local developers, a multinational automobile manufacturer, community-based organizations, retailers that sell cigarettes), schools, health care providers, the courts, and a county sheriff's office.

A Strategy for Success

A winning strategy for success in meeting our health protection goals is to expand the scope of public health—in every important dimension.

Four steps we need to take to execute this strategy are to: 1) strengthen our knowledge through applied, practice-relevant research; 2) translate that knowledge into practice and policy; 3) replicate throughout the country the best practices and models that work that are validated locally; and 4) spread the word about public health's successes to the public, to policy makers, and to new partners.

Front-line public health professionals—such as the Genesee County Health Department—and their partners play an indispensable role in all four steps.

First, we ultimately can achieve our health goals only if our tools and interventions are grounded in sound science. CDC and a number of other organizations support public health research and are developing public health research agendas. It is absolutely essential for your priorities to be reflected in those agendas. Front-line practitioners have the closest understanding of their communities' health needs and of their own need for improved tools and interventions. One of their vital roles is to communicate those needs to the people who put together the agendas and priorities that drive the allocation of research dollars. And it is not just the views of front-line practitioners that need to be articulated—so do those of policy makers and the entire spectrum of partners with whom public health departments collaborate. We need to expand the scope of those who help shape the nation's public health research agendas and programs. And I would like to invite your thoughts on the best way to establish a standing channel of communication about your public health research priorities and those of your colleagues throughout the country.

Second, it is clear that front-line public health practitioners and their partners have the leading role in translating the knowledge created through research into effective prevention practices and policies—and, as I noted a minute ago, in creating innovative interventions from the ground up. There are many, many success stories here but I think we all know that there also are many gaps between what empirical research and grounded experience say we should do and what actually is done on the ground. It's ironic to say this in Michigan, but one of the most glaring examples of such gaps on the national landscape is in fluoridation of public drinking water. What scientific studies find over and over is that fluoridation makes a major contribution to reduced cavities—dental caries—and that it poses no health risk, none at all. Yet there are vocal opponents of fluoridation and, for that matter, of childhood vaccination, who are convinced—by something other than empirical science—that fluoridation and vaccines harm health.

One of the most important successes in translating applied public health research into practice is in the area of secondhand smoke or environmental tobacco smoke (ETS). It was not too many years ago that a few public health scientists were the only ones who saw that ETS is a health threat. But their persistent research generated irrefutable evidence of harm and cities, counties, and states across the country have adopted increasingly tough smoking restrictions and exposure to ETS has dropped dramatically as a result. Many private businesses and other organizations have gone "smoke-free" because their local health departments reached out with that message.

For all of us, a critical "to do" in translating science into practice is to expand the scope of those who can get their hands on the science relevant to their own health priorities. One of the very best things CDC is doing is called the Guide to Community Preventive Services where a task force composed of distinguished, non-federal, multidisciplinary practitioners and conducts systematic analyses of published, peer-reviewed research on specific public health interventions. Based on the results, the task force decides which interventions to recommend and which not to recommend. For example, the Task Force strongly recommends community design policies that encourage walking and other

physical activity, as well as enforcement and education campaigns for use of seat belts and child safety seats in cars. The Task Force deliberately reaches out to policy makers and practitioners and also publishes detailed information about its methodologies and If you haven't done so already, let me urge you to go to "www.communityguide.org" and read the Task Force's recommendations and think about bringing them to the attention of the widest array possible of organizations that can use them in translating science into front-line practice.

Translating science and grounded experience into practice in only our own communities, however, is not enough. The next step toward significant, national success is to replicate nationally best practices and models that work on a nationwide scale. Local health departments, their partners, and—in particular--their national associations play a vital role. The National Association of Local Boards of Health and the National Association of County and City Health Officials, for example, communicate front-line innovations to their members across the country, as does the National Conference of State Legislators, the Council of State Governments, and the National Governors Association. The American Planning Association is doing the same with smart growth policies that promote physical activity and reduce pedestrians' risk of motor vehicle injury. Based on the "bench book" project I mentioned earlier, judicial educators in more than one dozen states are developing training in public health law for state and municipal judges that will be available nationally in the next year or two.

Fir its part, CDC actively disseminates information across the country about a wide range of public health best practices. Many of these are best practices that have been validated by colleagues, like you, who know what works on the front line. For instance, CDC published its "Best Practices in Tobacco Control" report in 1999 with explicit recommendations for the amount of money each state should spend on tobacco control. I don't believe CDC had ever issued that kind of recommendation before. It has been a valuable tool for state legislators and health officials. The report is a wonderful example of partnerships in action because the data that CDC used in developing those funding recommendations actually came from the successes four states had had with their comprehensive tobacco control programs: Arizona, California, Massachusetts, and Oregon.

Fourth, and last, we need to "spread the word" about the public health successes that can be generated by defining the scope of public health inclusively.

Schools, community-based organizations, and faith-based organizations need to know they can partner with public health agencies to provide health information, screenings, and other services that can focus effective prevention tools on the "urgent realities" that can keep children from being eager learners, adolescents from developing healthy independence, and adults from living healthy, productive, and satisfying lives.

Government leaders need to know that investments in upstream prevention can moderate spending for health care. Employers and workers alike need to know that partnering with their public health departments can help workers and their families stay healthy and help

restrain health care costs. There are very encouraging signs in this regard. The Union County, Ohio, collaboration is one example. Another is a collaboration between a large poultry producer and a north Georgia county health department that is providing preventive health services to employees.

An important, strategic goal for public health should be to contribute to economic wellbeing at the community and national levels—through protection against the "urgent threats" of pandemic influenza and other potentially catastrophic dangers and simultaneously against the "urgent realities" of chronic disease, preventable injuries, and lasting disabilities. This is an area where the Genesee County Health Department and its partners could make another immensely valuable contribution. There is great interest at CDC and throughout the public health community in gaining a deeper understanding of what is called "the business case for public health." Rigorous studies show that small investments in childhood immunization, diabetes prevention, tobacco control, and other, similar interventions can generate truly extraordinary returns in the form of better health and in cost avoidance. But I do not believe that similar calculations have been done for an entire community. Research to measure the community-wide return on investment in prevention would generate information of truly nationwide significance.

Finally, let's spread the word about public health to the college students who are seeking meaningful, inspiring careers. We can tell them that, as public health professionals, they can enjoy careers that are exciting, immensely beneficial for their communities, and deeply rewarding for themselves. Whether they practice as physicians, nurses, engineers, epidemiologists, health educators, laboratory scientists, environmentalists, attorneys, or in any of the 150-plus professions active in public health, they will find that the public health community is unrivalled for creativity and dedication Every day some 500,000 professionals come to work in 3,000 county and city public health agencies, dozens of tribal health agencies, the health departments of 50 states, the District of Columbia, Puerto Rico, and territories in the Caribbean and the Pacific Ocean. Every day they bring dedication, creativity, and energy to the job. They are complemented by equally creative and dedicated colleagues who work in the full spectrum of private and public organizations that comprise the nation's public health system, as well as by educators and researchers in academic settings. I can personally attest—as can you—that public health offers unrivalled opportunity to "make a difference."

I believe Americans will not achieve their full potential in the 21st century if the public health community does not deepen the partnerships that helped make the great public health achievements of the 20th century possible and, at the very same time, expand the scope of public health to include new partners who share our goals and who understand that advancing the health of Americans helps them achieve their own goals.

Many of you know Dr. Mike McGinnis, one of the great public leaders of our day. Dr. McGinnis spoke to the first-ever meeting of CDC partners at last week's "Leaders to Leaders" conference in Atlanta about his personal experiences in public health at the community, state, and national levels. His conclusion eloquently summed up one of the

most important themes of today's Symposium when he said that "All major public health achievements result from strategic partnerships."

In closing, I want to thank you again for letting me take part in the Premier Genesee County Public Health Week Symposium. The Symposium is itself a wonderful innovation and you may be sure that I will be an enthusiastic agent of contagion—good contagion, that is—and spread the word about what you are doing to colleagues at CDC and throughout the country as well.