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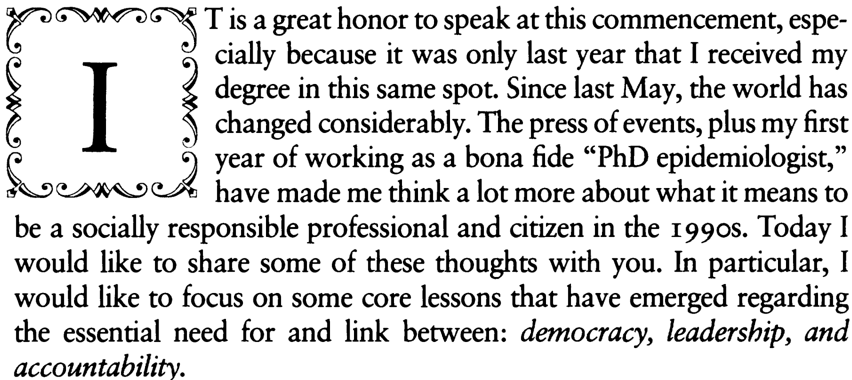
On Becoming a Public Health Professional: Reflections on Democracy, Leadership, and Accountability

Commencement Address, School of Public Health, University of California at Berkeley

NANCY KRIEGER



IT is a great honor to speak at this commencement, especially because it was only last year that I received my degree in this same spot. Since last May, the world has changed considerably. The press of events, plus my first year of working as a bona fide "PhD epidemiologist," have made me think a lot more about what it means to be a socially responsible professional and citizen in the 1990s. Today I would like to share some of these thoughts with you. In particular, I would like to focus on some core lessons that have emerged regarding the essential need for and link between: *democracy, leadership, and accountability.*

These days, it is impossible to pick up a newspaper without seeing yet another headline proclaiming another major shift in world events. The connection of these events to public health is far from trivial. As the history of public health repeatedly demonstrates, times of turmoil—of economic instability and altered migration patterns, of changing mores and political ferment—have always proved fertile ground for the propagation of epidemics. And, depending on which political forces come to the fore, such times also foster the development—or suppression—of new ideas and new approaches to improving the conditions under which we live and work. The thawing of the cold war, the upheavals in Eastern Europe and the Soviet Union, the looming economic consolidation of Western Europe and the rising significance of the Pacific Rim, the contracting economy of the United States, the growing debt of the Third World, and the intensified conflicts in South Africa, the Middle East, and

Latin America—all undoubtedly will influence patterns of health and disease in the times that lie ahead.

Yet, regardless of what the future holds, we still do not have answers to all our current problems. Here in the United States, hardly a day goes by without some new discussion of the environmental crisis, of the health care crisis, of who or what is responsible for ill health. We are continually confronted by the stark contrast between our enormously sophisticated and ever increasing biomedical knowledge, and the tenacity of many of our most basic public health problems. Right here in Alameda County, poor and minority children are caught in the midst of a totally preventable measles epidemic. Nationally, despite the proliferation of neonatal intensive care units, the decades-long decline in infant mortality has come to a virtual halt, and the two-fold gap between black and white infant mortality rates not only persists, but seems to be increasing. With the AIDS epidemic has come a resurgence in tuberculosis, while heart disease and cancer remain our major killers. And, though we have the *highest* per capita gross national product and health care expenditures of the top 33 developed countries in the world, the US ranks only 17th in years of life expectancy, and only 20th in infant mortality. Over 37 million people—one-sixth of our population—lack health insurance entirely. Clearly, something is askew.

Even in countries that do guarantee health care as a right, such as Canada and the nations of both Western and Eastern Europe, major public health problems are far from resolved. The gap between the health status of the poor and the rich continues to exist and may be growing. Accounts abound of environmental destruction, brought on by a mixture of incessant industrial expansion and poor economic planning. Occupational hazards still pose a significant threat to health, and extensive advertising continues to promote the equation of "good living," even "freedom," with the consumption of cigarettes. In the aftermath of the toppling of the Romanian government, a country where US cigarettes are apparently a coveted and scarce luxury item, a full page ad in the *New York Times* had the gall to proclaim: "In Romania, Kents are too valuable to smoke. Fortunately, we live in America."

In economically underdeveloped countries, moreover, the contradiction between the level of human knowledge and the depth of human suffering grows worse. Infant diarrhea, malaria, and other infectious diseases remain the big killers, linked by the social facts of poverty, overcrowding, and poor sanitation. Whether from preventable illness or

outright war, the toll of human destruction is high. As one critic has noted, the "equivalent of 20 nuclear bombs explodes every year in the world of underdevelopment without making a sound." Making matters worse, the so-called "development programs" sponsored by the World Bank and the International Monetary Fund are now tied to austerity measures that completely gut social and health services, and thus are eroding—not improving—the public's health.

These sorry facts demand an accounting. How can we improve the public's health? What must we do to secure not just a basic existence but a decent life for present and future generations?

ON DEMOCRACY

Out of this welter of pain and confusion, of changing patterns of disease and shifting centers of power, I believe that three vital requirements for public health can be discerned. They are: *democracy, leadership, and accountability*—whether under conditions of capitalism, socialism, or a mixed economy. And by democracy, I mean not simply whether people have a right to vote and to choose between candidates of different political parties, but whether the *entire* public has the right *and* the power—economic as well as political—to have a real say in how society operates. Democracy is about having a stake because you are a real participant. It is about knowing whom to hold accountable, and it is about having the power to hold them accountable. Democracy is not about letting priorities be set by a bureaucratic or technocratic elite, or by the "blind forces" of the market (which always turn a blind eye toward human suffering); it is about constructing a social agenda, based on human need, through informed and active popular participation at every level. The need for this kind of democracy is as necessary for public health here in the United States as it is in the Soviet Union, China, Latin America or, for that matter, in any region of our troubled world.

Concerns about the social requirements for public health are nothing new. The insight that patterns of health and disease are profoundly influenced by a society's structure—including its economic foundations and political framework—has been part of our heritage since the first days of the modern public health movement. During the late 1700s, poverty and disenfranchisement were recognized to be major determinants of disease. Then, with the advent of the Industrial Revolution in the 1800s, ground-breaking quantitative studies demonstrated how workplace and community conditions affect health—knowledge in turn

employed by the newly emerging working class in their fight for a better life. Capturing the spirit of those times, in 1848 Rudolf Virchow forcefully concluded that the solution to the typhus epidemic then ravaging an impoverished district in Germany could "be summarized briefly in three words: *full and unlimited democracy*."

Yet, in our present epoch of public health, these insights somehow have been muted. In an increasingly individualistic society, attention has turned inward, to "individual" risk factors. At the same time, the public has become more educated, and awareness of the limits of scientific "expertise" is on the rise. Nevertheless, our educational training continues to place health professionals at the center, as arbiters for how everyone else should live and how society should be organized. As we embark on the path of our professional careers, and look at the world changing around us, I think we should pause and ask whether this is indeed truly our role.

To consider this question, I think we must first remind ourselves that no one elected us to become public health professionals. What, then, does democracy mean for us? It means rejecting the role of paternalistically "serving the public," and instead recognizing that we have a particular set of knowledge and skills to share *with* the public—of whom, after all, we are a part. It means no longer dividing the world into "we" and "they," as in: "we know what's best for them," but instead thinking in terms of "us," and then asking: what would we want, what would we do, how would we live, if we were in "their" shoes, assuming we aren't wearing them already? It means acknowledging that forging and implementing the public health agenda requires a partnership with not only community and work-related organizations, but an active and informed electorate. With battles about AIDS, gun control, the environment, and other public health issues increasingly being fought out at the ballot, it is our urgent and democratic duty—as public health professionals—to educate the voters so that we, as a people, can make sound decisions about our public health policy.

Beyond this, democracy has yet another meaning for public health, especially when our work directly intersects with the raging moral controversies of the day. Where would we be in preventing AIDS, for example, if Senator Jesse Helms and his ilk succeeded in their attempts to ban educational materials about safer sex because they "promote homosexuality"? Public health cannot thrive without guarantees of a democratic discourse, and for such discourse to flourish, public health professionals

must join with others to defend basic democratic rights and values. Civil liberties are not an option; they are a necessity, for without these safeguards, democracy makes a mockery of the rights of minorities, and instead becomes the tyranny of the majority.

ON LEADERSHIP

This brings me to the next question: that of leadership. No matter how unpopular, our duty is to speak out about the causes of ill-health as we see them, to "name names," to challenge questionable priorities, and to take action to improve conditions. When we are told that there is not enough money to fund both cancer and AIDS research, should we not ask: is the issue really limited resources, or is it political priorities? With the cold war fast ending, must "national defense" continue to devour fully 66%—or $41 billion—of our annual federal research and development monies, while health is allotted only 12%, its $8 billion sum only twice the amount that Star Wars research receives? And when we are told that we cannot afford to finance both prenatal care and care for the elderly, is it not our place to ask why we, as taxpayers, can nonetheless be forced to pay at least $10 to 12 billion *per year* for the next 30 years to bail out the corrupt savings and loan industry? And when confronted by health insurance companies that increasingly seek to insure only the healthy, is it not our place to challenge their single-minded pursuit of profits, and instead insist that the rationale for health care is human need, not monetary gain?

Leadership also means speaking out about injustice, and being prepared to take up the fight within our own field as well as in the broader society. If we are serious about closing the gap between the health of minorities and whites, between the working class and those who effectively own or control our economic infrastructure, then we are talking about not only distributive justice, but restorative justice—about providing not only additional resources to communities that have endured discrimination and deprivation, but also affirmative action. As we look about us, we must ask: are the "experts" all white? Are they all men? Are they all affluent? Are they all straight? If so, we have a problem—because without the full range of views represented among those who research and analyze public health problems, we can be sure that the questions asked and the solutions proposed will be both slanted and sorely incomplete.

Moreover, the question of leadership is not only about *exerting* leader-

ship, it is also about recognizing the leadership of *others*. Once we understand that public health problems neither originate nor can be solved in isolation, once we see the links between, say, AIDS and not only other sexually transmitted diseases and drugs, but also the crisis of the health care system, homelessness and the collapse of inner cities, plus homophobia and racism, then the necessity of broad coalition politics becomes plain. And, in these coalitions, our role is to contribute our specific expertise while recognizing that we have much to learn from the expertise of others; *this* is the fundamental strength of coalition.

ON ACCOUNTABILITY

Lastly, what does accountability mean for us? It means acknowledging the debt we owe to the working people—that is, the anonymous taxpayers—whose labor generates the wealth that, in the form of taxes or corporate donations, knowingly and unknowingly subsidizes our work, research and education. It means squarely facing the responsibility we bear toward those who are forced to rely on government programs or to depend on government regulations, since so often our work shapes the parameters of their lives. It means making sure we communicate our findings and bring our concerns not just to other health professionals, but to the very people who are the *subject* of our work. It means that the public's interest must be at the heart of the hypotheses we explore and the policies we implement. It means treasuring intellectual honesty, and acknowledging that science is inherently at once objective and partisan, that our theories are never value-free, that our knowledge is not neutral, but is always informed by our broader view of the world. And it means knowing whence we speak, being cognizant of our own background and biases, so that we know from whom else we need to hear. And most importantly of all, it means holding accountable those people and institutions whose decisions and actions imperil public health.

CONCLUSION

These questions—about social justice and public health, about democracy, leadership, and accountability—have played a central role in my development as a public health professional. Far from lending themselves to easy answers, they constantly challenge and motivate me in my epidemiologic research regarding race, class and cancer, and my interest in epidemiologic theory and the social production of disease. They are also central to my concerns about the accuracy of the US census, my

activism around AIDS policy and the need for a national health program, and my involvement in the National Rainbow Coalition.

Over time, I have become increasingly aware that improving the public's health requires the efforts of *all* of us, whether we work at the lab bench, with computers, or "out there" in the community. And as we commence our professional lives, it behooves us to remember that the task of prevention, the provision of care, the search for a cure—these *never* have been simply technical exercises. Instead, they are activities fundamentally shaped by social priorities, by the availability of resources, and by the multiple agendas of those who set and react to these priorities, who control and contest these resources. The facts of social suffering and ill health are neither a mystery nor a fluke. They are dryly documented in our government statistics about poverty, in our endless reports about morbidity, mortality, and life expectancy. If our commitment is to eliminating socially-produced disparities in health, then we must seek to work in coalition with others—both in and outside the field of public health—so as to challenge the social forces that produce and reproduce the patterns of disease now prevalent in our society.

Let me close with some lines of poetry by Dante and Bertolt Brecht. Above my desk at work hangs a poster with a phrase from Dante's *Inferno*, and I keep it there as a reminder as to what this is all about. I quote:

> The hottest places in hell are reserved for those who,
> in time of great moral crisis, maintain their neutrality.

And the poem by Brecht is one of his last, and is entitled "And I Always Thought." A collective appeal for compassion, integrity, and solidarity, it says:

> And I always thought: the very simplest words
> Must be enough. When I say what things are like
> Everyone's heart must be torn to shreds.
> That you'll go down if you don't stand up for yourself.
> Surely you see that.

Our mandate is clear. It is to make sure our voices are heard, clearly. It is for each of us to stand up for our beliefs, and to stand together as we work *with* the public to defend and improve the public health. It is to know where we fit, in this moment of history, and to take history into our hands as we help shape the public health agenda. And, as we carry

out our work, we cannot afford to accept a narrow view of professionalism that somehow would have us remain "above the fray." As the history of public health amply demonstrates, it is not a contradiction to be a public health professional and an activist; both are necessary to fulfill our public health goals.

Finally, we must always remember that our work is driven not just by negatives—preventing disease, preventing premature death—but also by positives. Public health in its broadest sense is public welfare, and its foundations lie in social justice. It is our responsibility, as public health professionals at once expert and partisan, to help build a world in which health truly can exist for all—a world free of discrimination and oppression, free of poverty and underdevelopment, free of warfare and the threat of nuclear and environmental destruction, a world in which we *all* can live, love, work and die with our dignity intact and our humanity cherished.

We have a lot to do. Let's keep our eye on the prize, and get on with the work. Thank you.