

American College of Preventive Medicine

**Policy Committee Report
November 2003**

Chair: Mark Johnson
Vice Chair: Chris Armstrong

Staff: Mike Barry

Since reporting to the Board in June 2003, the ACPM Policy Committee and policy staff have focused on: (1) advocating to strengthen preventive medicine residency funding, (2) preparing an ACPM policy statement on health insurance reform, (3) preparing for the 2003 Interim Meeting of the AMA House of Delegates, (4) reviewing and responding to prevention and public health articles, and (5) carrying out other legislative and policy advocacy activities.

Advocacy for Preventive Medicine Residency Training

ACPM has continued targeted advocacy aimed at assuring funding for preventive medicine residency and other health professions programs. A primary focus of ACPM's activities has been on restoring funding for the HRSA Title VII health professions programs, which were zeroed out in both the President's budget and Senate appropriations bill for FY 2004. The House bill provides for an 11 percent funding cut from the FY 2003 level. Currently, the FY 2004 Labor/HHS/Education appropriations bill is being considered by a House/Senate conference committee, and the fate of Title VII funding for FY 2004 is uncertain.

This is the first time in many years that funding for the programs has been eliminated in either of the House or Senate spending bills. To address this problem, ACPM has:

- Mobilized grass roots support from its membership to petition Congress to support restoration of Title VII funding. ACPM developed and distributed to current Title VII grantees, all PMR programs, and its full membership a series of action alerts that generated many letters to congressional representatives and contributed to several congressional members signing on to internal member-only sign-on letters. ACPM also collected anecdotal evidence identifying the impact of eliminating Title VII funding on PMR programs.
- Worked with the Health Professions and Nursing Education Coalition (HPNEC) on a variety of activities in support of health professions funding, including legislative strategy sessions and development of sign-on letters and advertisements aimed at congressional policy makers.
- Conducted visits to congressional staff of the Labor/HHS/Ed subcommittees to urge support for restoring Title VII funding.

Among other avenues for increasing funding for preventive medicine residency programs, ACPM is re-focusing attention on Medicare GME financing. With the future of Title VII uncertain, the momentum for Medicare reform, and a renewed focus on preparing the public health workforce, ACPM believes the time is right to petition the Center for Medicare and Medicaid Services (CMS) to make changes to the Medicare GME payment rules to include preventive medicine. As such, ACPM: (1) sent a letter to Health and Human Services Secretary

Tommy Thompson with several policy recommendations, including recommendations to expand Medicare GME to include preventive medicine (see Attachment A), and (2) sent a letter and white paper to CMS Administrator Tom Scully urging regulatory changes that would pave the way for PMR programs to receive Medicare GME funding for training (Attachment B). ACPM obtained endorsements from most of the organizations of the Preventive Medicine Leadership Forum. ACPM is attempting to set up a meeting with Mr. Scully to continue advocating for GME support.

In addition, ACPM prepared a background paper on the importance of a well-trained preventive medicine workforce for use internally at the CDC on a potential proposal to fund training slots at all GPM/PH training programs around the country. The proposal is being considered as part of a larger CDC prevention research initiative. ACPM met with staff of Senator Harkin in follow-up to a meeting between Dr. Gerberding and the Senator at which this proposal was discussed. (See Attachment C for a copy of ACPM's background paper.) On November 18, Jud Richland will be participating in a meeting with Secretary Thompson to discuss health professions issues and will make the case for Medicare support for GME funding for preventive medicine residency funding.

Health Insurance Policy Statement

Pursuant to the February meetings of the Policy Committee and Open Policy Forum in San Diego, ACPM went back to the drawing board on its health insurance policy statement. The thrust of the comments offered at the Forum and by committee members was that the statement was too detailed and too prescriptive about how to reconfigure the health care system, focusing on issues (e.g., financing and regulatory provisions) beyond the sphere of the College's influence. The Policy Committee passed a motion referring the statement back to the Health Insurance Policy Subcommittee and asking for a shorter consensus statement of ACPM's core principles building on ACPM's past policies on this issue. Once ACPM stakes out its position, it will be able to compare it to the reform proposals of other entities, determine which proposals to endorse, and form strategic alliances to advocate for the principles.

The subcommittee subsequently has pared back the statement to be a much shorter consensus statement on core principles and concepts that focuses on universal access and assurance of preventive services. The Subcommittee is forwarding the revised statement to the full Policy Committee and the Board for review and, hopefully, adoption at their November meetings in San Francisco.

AMA House of Delegates

The ACPM Executive Committee has approved two ACPM-sponsored resolutions for submission to the AMA for consideration at the House of Delegates 2003 Interim Meeting in December. The first resolution calls on the AMA to support the renewal and strengthening of the 1994 Assault Weapons Ban, which is set to expire in September 2004. ACPM secured the following co-sponsors on the resolution: American Academy of Pediatrics; American Association of Public Health Physicians; American College of Physicians; and American

College of Surgeons. The American College of Emergency Physicians is also considering sponsorship. The second resolution, which was co-sponsored by AAPHP, calls on the AMA to advocate for environmental and policy interventions to promote physical activity. At the time of this writing, the ACPM Policy Committee was reviewing a third resolution asking the AMA to support a series of actions that would strengthen regional and national terrorism and disaster preparedness and response. (See Attachment D for copies of the resolutions.)

ACPM, in conjunction with the Section Council on Preventive Medicine, is also planning a reception at the Interim Meeting to honor ACPM Past President Doug Scutchfield, who will receive the prestigious AMA Distinguished Service Award during the Opening Session of the House. ACPM nominated Scutch for the award.

Response to Prevention and Public Health Articles

ACPM prepared responses to the following articles published in recent months:

- A September 14 article in Parade Magazine titled “Stay Healthy For a Lifetime,” by Dr. Isadore Rosenfeld. The article recommended a variety of preventive screenings and other services to consumers, many of which are not supported by the scientific evidence. (See Attachment E for ACPM’s letter to the editor.)
- An article in the July/August issue of *Health Affairs* (“A Prescription for Change: The Need For Qualified Physician Leadership in Public Health”) calling attention to the critical shortage of public health physicians. ACPM issued a press release praising the article and delineating its own recommendations for addressing the shortage of preventive medicine physicians (see Attachment F).

Other Policy Activities

- The Senate unanimously passed the "Genetic Information Nondiscrimination Act of 2003" (S. 1053). S. 1053 provides protections against discrimination based upon genetic information by health insurers and employers. ACPM sent letters to key congressional members supporting the bill in June. The bill is consistent with ACPM Policy 2002-060 (F), adopted by ACPM in November 2002.
- ACPM Fellow Erica Frank has been actively representing the College on activities related to the U.S. involvement in international trade agreements and their potential impact on public health. These actions are consistent with the resolution passed by ACPM and submitted to the AMA in May 2003.
- Work on the Job Market Initiative (JMI), other than occasionally posting relevant job announcements to the JMI jobs database, has been suspended pending further negotiations between ACPM and AAPHP. The Boards of both organizations are considering an agreement to share staff resources.
- The ACPM Policy Committee has reviewed a position paper developed by Medem, Inc. on the use of on-line communication services for healthcare delivery. Although the committee made a number of suggestions for improving the paper, it recommends that the Board endorse the paper and that ACPM submit the comments from the Policy Committee to Medem along with its letter of endorsement (to be distributed to Board electronically).

- The Policy Committee reviewed and recommended for adoption the Principles of the Ethical Practice of Public Health, developed by the Public Health Leadership Society. The Board subsequently voted to endorse the Principles (See Attachment G).
- ACPM agreed to oppose congressional legislation (S. 659) that would provide legal immunity to the gun industry.
- ACPM issued a call for policy resolutions from the members in the most recent edition of *ACPM News*. Resolutions will be heard at ACPM's upcoming Open Policy Forum at *Preventive Medicine 2004* in Orlando.
- ACPM did extensive research about on-line grassroots advocacy software and software vendors. ACPM would like to use such a tool to facilitate mobilizing ACPM members into action vis-à-vis national prevention policy initiatives, increasing ACPM's visibility on Capitol Hill, and possibly expanding membership. Because the software and support would require a significant financial investment by ACPM (likely \$5,000 initially), ACPM has agreed to seek funding to support such investment within the broader context of ACPM's proposed Center for Preventive Medicine.
- See Attachment H for ACPM's policy compendium since the July Board meeting.

ACPM Policy Committee Report, November 2003
LIST OF ATTACHMENTS

- Attachment A** ACPM recommendations to Secretary Thompson to strengthen the role of prevention in the health system
- Attachment B** Letter and white paper to CMS Administrator urging changes to Medicare GME to include preventive medicine
- Attachment C** Background paper on the shortage of preventive medicine physicians prepared for CDC
- Attachment D** ACPM policy resolutions for AMA House of Delegates, Interim 2003 meeting
- Attachment E** ACPM letter to health editor of Parade magazine
- Attachment F** ACPM press release in response to *Health Affairs* article on public health physician shortage
- Attachment G** Principles of Ethical Practice of Public Health
- Attachment H** ACPM policy compendium, July – October 2003

September 9, 2003

The Honorable Tommy G. Thompson
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Thompson:

At the recent *Steps to a HealthierUS* conference, you asked the health community to suggest actions you can take to strengthen the role of prevention even further. The American College of Preventive Medicine (ACPM) is pleased to recommend several actions you can take that will strengthen the nation's ability to promote health and prevent disease—actions that do not require legislative changes. As the national medical specialty society that represents physicians who specialize in disease prevention and health promotion, ACPM commends you for initiating the *Steps to a HealthierUS* initiative and for the priority you have placed on the vital role of prevention in the health of our citizens.

ACPM's recommendations are summarized below and further explained in the attached document. ACPM recommends that, as Secretary, you should:

1. Revise existing Medicare regulations to allow Medicare Graduate Medical Education (GME) reimbursement for preventive medicine residency programs.
2. Allow Medicare to provide insurance coverage for evidence-based screening tests by stipulating that such tests are equivalent to diagnostic tests.
3. Double the amount of funds over the five years beginning in 2005 that NIH provides for population-based prevention research.
4. Increase support for the U.S. Preventive Services Task Force and the Task Force on Community Preventive Services.
5. Lead the development of a Department-wide research agenda that gives priority to research into the leading causes of preventable morbidity and mortality, namely, tobacco use, diet, and physical activity.
6. Support through CDC the training of preventive medicine physicians to ensure appropriate leadership for carrying out a national prevention research agenda.
7. Fund Medicare and Medicaid demonstration projects to carry out population-based disease management programs.

ACPM applauds your efforts to promote health and prevent disease across the nation. We would be pleased to have the opportunity to discuss our recommendations with you. If we can be of assistance, please contact ACPM's Executive Director, Jud Richland, at 202-466-2044, ext. 110. Thank you once again for your careful consideration of these recommendations.

Sincerely,

Robert G. Harmon, MD, FACPM
President

STRENGTHENING THE ROLE OF PREVENTION IN THE HEALTH SYSTEM

Actions Recommended to the Secretary of Health and Human Services by the American College of Preventive Medicine

Modernizing Medicare

- ◆ Revise existing Medicare regulations to allow Medicare Graduate Medical Education (GME) reimbursement for preventive medicine residency programs. The regulations should be revised in two ways:
 - First, Medicare GME funding should be available for residency programs that train physicians in public health, health promotion, and disease and injury prevention (e.g., epidemiology and risk communication). Currently, Medicare GME funding is available only for the training of physicians involved in direct patient care. Typical training experiences for preventive medicine residents—training experiences that are not eligible for GME payment—include such things as: developing and implementing programs to increase screening rates for diabetes, heart disease, and hypertension; conducting influenza and pneumococcal immunization sessions in the community (e.g., at senior centers); and improving case management tools for patients with multiple and complex health problems.
 - Second, HHS should expand the definition of qualified non-hospital provider sites where residents are permitted to train and for which residency programs may receive GME payment. Preventive medicine residents typically spend much of their residency training in non-hospital sites such as state or local public health departments, schools of public health, and a variety of community-based settings. Medicare does not currently provide GME support for training in public health agencies and in many other community-based settings where prevention is practiced. In addition, GME payments should be made directly to the residency programs, which would ensure better coordination of residents' training experiences.
- ◆ Define screening tests as diagnostic tests to ensure their coverage under Medicare. ACPM has long advocated for congressional changes that would allow Medicare to cover all preventive services determined to be effective by such authoritative bodies as the U.S. Preventive Services Task Force. Short of such broad-based congressional action, however, HHS can take a key step toward improving Medicare coverage for preventive services by stipulating, through regulatory action, that these screening tests are equivalent to diagnostic tests. Currently, some tests—such as screening for hearing impairment, screening for increased blood lipid levels, and screening for depression—are reimbursed by Medicare only if the physician designates these as diagnostic tests. These services cannot be reimbursed if the physician designates these as screening tests.

Promoting Prevention Research

ACPM also recommends several actions that will enhance prevention research and improve evidence-based decision-making:

- ◆ Double the amount of support NIH provides for population-based research in order to improve our ability to prevent the occurrence of disease and disability. According to NIH, in FY 2001 the

agency spent \$2 billion on population-based prevention research via programs supported by 22 of NIH's Institutes and Centers. Beginning in FY 2005, NIH should begin the process of doubling the funds allocated to population-based prevention research, completing this process in 2009. At least one million Americans die prematurely each year from preventable causes. This investment can have a significant impact on our nation's efforts to reduce the burden of preventable mortality. These dollars should be directed toward collaborative efforts by public health departments, schools of public health, departments of preventive/community medicine in medical schools, Prevention Research Centers, and local public health associations.

- ◆ Increase support for the U.S. Preventive Services Task Force, Task Force on Community Preventive Services, and Healthy People 2010 initiative in order to increase research and implementation of evidence-based prevention recommendations.
- ◆ Develop a Department-wide prevention research agenda with priority given to leading causes of morbidity and mortality and to important research gaps identified by the U.S. Preventive Services Task Force, Task Force on Community Preventive Services, and Healthy People 2010 initiative. Researchers have determined that tobacco use, poor diet, and physical inactivity are the risk factors that account for the greatest number of preventable deaths. HHS should continue to strengthen research into these risk factors and should report annually on progress toward meeting the research objectives.
- ◆ Support the Centers for Disease Control and Prevention's proposal to enhance the prevention research infrastructure, particularly through the training of physicians who specialize in preventive medicine. Support for additional preventive medicine residency training slots would ensure appropriate leadership for carrying out a national prevention research agenda.

Disease Management and Care Coordination

- ◆ Fund both Medicare and Medicaid demonstration projects to test population-based disease management programs. Medicare demonstration projects should target fee-for-service beneficiaries who have high-cost diseases affecting broad segments of the Medicare population, such as congestive heart failure or diabetes. Medicaid demonstration projects should encourage partnerships between state Medicaid agencies and state and local health departments.. State and local public health agencies have extensive experience working with low-income patients, including Medicaid beneficiaries. Encouraging health departments to lead efforts to provide disease management and care coordination services, including case-finding and case management services, can promote the provision of preventive and primary care services for vulnerable populations who may otherwise receive little or no medical supervision and who may generate significant health care expenditures.

October 28, 2003

Thomas A. Scully
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Scully:

As Congress debates Medicare reform and a prescription drug benefit plan, the undersigned organizations urge the Centers for Medicare and Medicaid Services to take action on a less costly but potentially more far-reaching issue: Medicare GME funding for preventive medicine residency training.

Preventive medicine is one of only two accredited medical specialties of which we are aware (the other being pediatric residency training at freestanding children's teaching hospitals, which has its own dedicated GME funding source) that receives practically no support from Medicare GME. As a specialty area that concentrates on keeping populations, including older Americans, healthy and on preventing the progression of disease, preventive medicine should be included in the Medicare GME payment formula. We offer two specific recommendations, neither of which would require congressional action, to make this happen:

1. CMS should include the types of activities carried out by preventive medicine residents—activities to promote health and prevent disease, disability, and death—in the definition of “patient care” for the purposes of GME payment.
2. CMS should expand the definition of qualified non-hospital provider sites where residents are permitted to train and for which residency programs may receive GME payment to include community-based sites (such as public health agencies) where preventive medicine residents typically train.

Enclosed is a brief white paper that provides further background on the issue and rationale for our recommendations. We would appreciate the chance to meet with you and/or key CMS staff to discuss our recommendations. We will follow up with you in the next few weeks to set up a meeting. We look forward to initiating a dialogue with CMS and to working together to overcome the barriers to GME funding for preventive medicine.

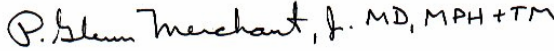
Sincerely,



Russell B. Rayman, MD
Executive Director
Aerospace Medical Association



Mary Ellen Bradshaw, MD, MPH
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P. Glenn Merchant, MD, MPH & TM
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N. Lynn Eckhert, MD, MPH
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John P. Holland, MD, MPH
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Jacqueline M. Moline, MD, MSc
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**Medicare GME Funding of Preventive Medicine Residency Programs:
The Need for Action**

BACKGROUND / PROBLEM STATEMENT

Preventive medicine is one of 24 medical specialties certified by the American Board of Medical Specialties. Preventive medicine encompasses three specialty areas — Public Health and General Preventive Medicine, Occupational Medicine, and Aerospace Medicine. Preventive medicine physicians are trained both in clinical medicine as well as in “population medicine,” which includes training in such areas as epidemiology, biostatistics, and environmental medicine.

Residency programs in preventive medicine are accredited by the Accreditation Council for Graduate Medical Education (ACGME). Yet, preventive medicine residency training is one of the only types of medical residency training that receives almost no Medicare GME funding. (The only other type of residency training of which the undersigned organizations are aware that receives little or no GME support is pediatric residency training at freestanding children’s teaching hospitals. A freestanding program, the Children’s Hospitals Graduate Medical Education Program, which is administered by the Health Resources and Services Administration, supports residency training in this area.)

Two important sources of funding for preventive medicine residency programs are HRSA’s Title VII Health Professions program and the National Institute of Occupational Safety and Health’s Education and Research Center Training Grants (ERCs). However, these funding vehicles support only a small portion of public health and general preventive medicine and occupational medicine residency programs and are subject to the vagaries of the congressional appropriations process.

Preventive medicine residency programs typically piece together funding from a variety of sources to support their programs. However, programs are finding it increasingly difficult to obtain external funding. The result is that the pipeline of preventive medicine physicians is steadily shrinking, a trend compounded by the fact that Medicare GME does not provide support to preventive medicine residency programs. Thus, the supply of physicians trained to administer community- and worksite-based programs that promote health and prevent disease is growing smaller. These programs often represent cost-effective approaches to keeping older Americans healthy and active.

Thus, the undersigned organizations recommend that the Center for Medicare and Medicaid Services amend the federal regulations governing the Medicare program to enable preventive medicine residency programs to receive Medicare GME funding, just as ACGME-approved residency programs in nearly all other medical specialties do. Expansion of Medicare support for training preventive medicine residents should be viewed as an investment in early detection of disease and as a means of keeping more of the elderly fit, safe, and well-nourished.

THE SOLUTION

There are two regulatory barriers that need to be amended in order for preventive medicine residency programs to become eligible for Medicare GME funding. First, GME funds support direct patient care. Medicare has interpreted this to refer to one-one-one interactions between

physicians and patients and not to such activities as developing disease screening programs, in which preventive medicine residents are so actively engaged. Second, the Medicare regulations limit support for training in non-hospital settings to a small number of narrowly-defined settings that do not account for many important sites in which preventive medicine residents typically practice. These barriers are described in greater detail below.

Direct Patient Care

The Medicare GME program supports the training of physicians who are involved in “patient care.” Medicare has generally interpreted patient care to be those services provided by a physician directly to an individual patient.

The question of what constitutes “patient care” bears directly on the question of what constitutes the practice of medicine. Perhaps the best way to determine what constitutes the practice of medicine is to identify those medical specialties that have been approved by the American Board of Medical Specialties. Preventive Medicine is one of 24 specialties that have met the ABMS criteria and have been approved by ABMS. (A complete list of ABMS-approved specialties can be found at www.abms.org.)

In addition, many states and localities require the state or local health director to be a physician. This is not because the health director will be responsible for treating patients directly; rather, it is because many jurisdictions have concluded that physicians—who are licensed to prescribe medical interventions without oversight—are best equipped to make decisions that affect large numbers of people and to administer a wide range of public health programs. Such positions are frequently held by physicians who are board-certified in one of the preventive medicine specialties. In fact, some jurisdictions, such as the Commonwealth of Virginia, require that the health director be board-certified in preventive medicine.

The examples below are typical of the work carried out by preventive medicine residents. These residents:

- ◆ Design programs to monitor and increase adherence to prescription regimens among homeless and underserved individuals in neighborhood clinics.
- ◆ Develop and implement culturally appropriate health promotion and disease prevention activities for older Americans.
- ◆ Develop better tools for assessing case complexity and improving case management of older individuals with multiple health problems.
- ◆ Evaluate the performance of nurse call centers that provide medical advice to seniors.
- ◆ Identify and implement strategies for increasing immunization rates among seniors.
- ◆ Provide disability determination and management services to workers, including those covered by federal programs such as Medicare.
- ◆ Develop strategies to maintain health and productivity for older working Americans.

These are just a few of the many types of training experiences that are an essential component of training for preventive medicine residents. These and other similar activities constitute important patient care services; hence, CMS should provide support for these types of training activities

through Medicare GME by including the provision of community-based preventive services under the definition of patient care.

Qualified Non-Hospital Providers

The Balanced Budget Act of 1997 (Section 4625) permits the Secretary of Health and Human Services to “establish rules for payment to qualified nonhospital providers for their direct costs of medical education...” The statute defined qualified non-hospital providers to include federally qualified health centers, rural health clinics, Medicare+Choice organizations, and “such other providers (other than hospitals) as the Secretary determines to be appropriate.” CMS, under the authority granted to the Secretary by the BBA of 1997, should issue a rule that specifies preventive medicine residency training sites be included for payment under Medicare GME as qualified non-hospital providers.

Preventive medicine residents typically spend almost all of their residency training in non-hospital sites such as city, county, and state health departments; community and occupational health clinics; schools of public health; corporate worksites; and managed care and other health care provider organizations. For example, public health and general preventive medicine training programs require that each resident spend at least one month (although most spend more time) at a public health agency, such as a local health department or department of human/social services. Public health agencies administer community programs that not only affect the health of entire populations (including the Medicare population) of a geographic area, but also provide direct health care and preventive services to medically indigent and underserved individuals. Unfortunately, Medicare does not currently provide GME support for training in public health agencies and in many other community-based settings where prevention is practiced.

Residents also train at health plan facilities, where they might, for example, develop and implement programs to increase screening rates for diabetes, heart disease, and hypertension; at senior centers, where they might conduct influenza and pneumococcal immunization sessions; and at community health centers, where they might implement disease management protocols for patients with multiple and complex health problems. In addition, preventive medicine residency programs provide academic training that provides residents with the didactic preparation needed for them to excel in their practicum rotations. All of these types of sites and training experiences provide preventive medicine residents with unique skills that are vital in improving health care delivery systems.

For this type of health care to continue to be provided, it is imperative that preventive medicine residency training sites be included as qualified non-hospital provider sites that can receive direct Medicare GME funds.

DISCUSSION

Because preventive medicine training spans the boundaries of clinical medicine and public health, it does not “fit” neatly into the traditional molds of medical education and hospital-based training envisioned by the creation of the Medicare GME financing system nearly 40 years ago. Nevertheless, the enabling legislation for Medicare GME, particularly the changes made under the 1997 BBA, provides the Secretary and the Centers for Medicare and Medicaid Services with sufficient flexibility to recognize and fully fund the training of the preventive medicine workforce. Such action would contribute significantly to the health and well-being of the nation’s seniors and can be accomplished without wide-scale reform of the GME financing system.

Ironically, other parts of the statute concerning Medicare GME funding recognize the importance of preventive medicine as a medical specialty. In 1986, Congress passed Medicare GME legislation that limited full Medicare GME reimbursement for all physicians in training to a defined period during residency. However, the 1986 law included exemptions for preventive medicine and geriatric medicine allowing programs training in these specialties to receive full funding for an additional period comprised of the first and second years of fellowship training. Unfortunately, this recognition has not translated into Medicare GME funds for preventive medicine residency programs for the reasons outlined earlier in this paper.

CMS is urged to carry out its commitment to the health of the nation’s seniors and to the importance of preventive care in graduate medical education by including preventive medicine in the definition of patient care and by expanding the types of training sites for GME reimbursement to those primarily offered through preventive medicine residency programs.

ENDORISING ORGANIZATIONS

Aerospace Medical Association (AsMA)
American Association of Public Health Physicians
American Board of Preventive Medicine (ABPM)
American College of Occupational and Environmental Medicine (ACOEM)
American College of Preventive Medicine (ACPM)
Association of Teachers of Preventive Medicine (ATPM)
Joint Council of Preventive Medicine Residency Directors (JCRD)
Occupational Medicine Residency Program Directors

**A Public Health Crisis:
The Shortage of Physicians
Trained in Preventive Medicine**

American College of Preventive Medicine

August 15, 2003

A Public Health Crisis: The Shortage of Physicians Trained in Preventive Medicine

OVERVIEW

As a recognized medical specialty for over 50 years, preventive medicine is unique in that its focus is population-based rather than centered on individual patients. Preventive medicine is the only one of the 24 medical specialties recognized by the American Board of Medical Specialties (ABMS) that requires training in both clinical medicine and public health. Preventive medicine physicians receive training in clinical preventive services (such as immunizations, screening, and counseling) and population-based health sciences (such as biostatistics, epidemiology, environmental and occupational health, planning and policy development, management and evaluation of health services, informatics, and the social and behavioral aspects of health and disease). They gain critical knowledge in population and community health issues, disease and injury prevention, disease surveillance and outbreak investigation, and public health research. Preventive medicine physicians are employed in state and local health departments, federal government agencies, hospitals, HMOs, community and migrant health centers, industrial sites, occupational health centers, academic centers, private practice, and the military.

DEMAND

In today's health care environment, the tools of preventive medicine are growing in importance. As the body of evidence supporting the effectiveness of clinical and population-based interventions continues to expand, so does the need for specialists trained in preventive medicine—specialists who can influence policy and develop programs to assure this new knowledge is integrated into health care delivery systems.¹

A variety of factors, including globalization, rapid demographic shifts, and technologic advances, are hastening the need to refocus attention and resources away from traditional biomedical efforts toward population health. The ecological model recognizes evidence that health is determined relatively little by health care per se and far more by multiple other factors, including genetics, the social and physical environment, education, employment, and behavior.²

An Institute of Medicine Report “Priority Areas for National Action: Transforming Health Care Quality” identifies 20 priority areas. Many of these areas incorporate the skills of preventive medicine physicians, including tobacco dependence, prevention of medical errors, obesity, immunizations, care-coordination, self-management/health literacy, evidence-based cancer

screening, major depression screening, and prevention of ischemic heart disease.³

Organizations across the spectrum have recognized this growing demand for public health and preventive medicine professionals. The Health Resources and Services Administration's (HRSA) Bureau of Health Professions, using data extracted from the Department of Labor, reports that the demand for public health professionals will grow at twice the rate of all occupations between 2000 and 2010.⁴ The Council on Graduate Medical Education (COGME) has made recommendations for residency programs to recognize the patient in the context of the population or community, partner with health plans to establish practical teaching sites, and emphasize disciplines that are basic to contemporary medical practice such as epidemiology and population-based care, health care policy and systems, disease prevention and wellness, and computer information skills.⁵ In addition, the nation's medical schools are devoting more time and effort to population health topics.⁶ The 1998 Association of American Medical Colleges (AAMC) medical school graduation questionnaire indicates that students believe that inadequate time is devoted to instruction in biostatistics (35%), epidemiology (39%), occupational medicine (61%), practice management (76%), quality assurance in medicine (76%), and medical socioeconomics (78%).⁷ These are just a few of the examples demonstrating the growing demand for preventive medicine professionals.

The recent focus on potential terrorist attacks on the United States is also driving the demand for these skills. Many public health leaders question the ability of the current public health workforce to deal with such emergencies, including outbreaks of infectious disease. Yet the skills needed to effectively prepare for and respond to bioterrorism and other public health threats—epidemiologic surveillance, disease prevention and containment, understanding and management of the health system—are at the heart of preventive medicine training and public health practice.¹

SUPPLY

According to HRSA and health workforce experts, there are shortages in many public health occupations, including preventive medicine physicians. In 2000, only 7,011 physicians self-designated as specialists in preventive medicine in the U.S., down from 7,734 in 1970. The percentage of total U.S. physicians self-designating as preventive medicine physicians decreased from 2.3% to 0.8% over that time period.⁷ Among specialty areas of preventive medicine, physicians designated as general preventive medicine or public health comprised 52.2 percent of total preventive medicine physicians in 1975 and only 46.3 percent in 1997. Physicians working in

the public health sector constitute only 0.2% of all U.S. physicians.⁷

Consistent with the trend of fewer preventive medicine specialists is the decline in the number of preventive medicine residency programs, decreasing from 90 in 1998-1999 to 83 in 2003-2004. Likewise, the total number of preventive medicine residents in training declined over the same period from 420 to 371.⁸

The decline in preventive medicine physicians is having an impact on public health leadership at the state and local levels. Data from the National Association of County and City Health Officials show that only 23 percent of local health agencies are directed by physicians and 8 percent are directed by physicians who have master of public health (MPH) degrees or are fellows in the American College of Preventive Medicine.⁹ Eleven states have no appointed physician leaders in their entire local public health system, and twenty-nine states do not have physician state health directors/commissioners. These data validate a long-term trend. A 1988 Institute of Medicine (IOM) report found a 22.5 percent decline in state health agency physicians from 1977 to 1982. This trend could hinder health departments' response capabilities during future public health crises. A recent article on public health leadership trends showed that health department directors who were not physicians had difficulty handling serious outbreaks and other medical emergencies.⁹

One explanation for the current situation may be the past success of public health. Since major foodborne or waterborne disease outbreaks have become rare, elected officials may not see a need to train and hire public health physicians. Moreover, many do not recognize the difference between physicians who practice traditional medicine and those who are public health specialists. Thus, many of the physicians appointed as public health leaders do not have public health training.⁹

The lack of public health physicians is not surprising given the dearth of medical faculty qualified to teach public health and preventive medicine. Data from the AAMC Faculty Roster indicate that among a total of 88,782 U.S. medical school faculty, there are only 2007 (2.3 percent) faculty members who have an MPH degree, 484 (0.5 percent) who have completed preventive medicine training, and 279 (0.3 percent) board-certified in preventive medicine.⁷

ACPM is deeply concerned about the shortage of preventive medicine-trained physicians and the ominous trend of even fewer training opportunities. The decline in numbers are dramatic considering the existing critical shortage of physicians trained to carry out core public health activities. This deficiency will lead to major gaps in the expertise needed to deliver clinical prevention and community public health. The impact on the health of underserved populations may

be profound.¹

FUNDING

The primary reason the pipeline of preventive medicine physicians is shrinking is that preventive medicine residency programs are inadequately funded.¹⁰ The critical skills needed to manage today's health departments in an era of emerging threats (both natural and intended) are taught in preventive medicine residency programs, yet financial support for such programs is weak.⁹

Traditional graduate medical education funding comes from patient care dollars. In contrast to the other Graduate Medical Education (GME) programs, preventive medicine programs receive practically no support from Medicare financing.⁷ The health care provider model used for Medicare GME funding links payments for clinical training to patient care, and therefore provides no support for training that does not occur in patient care settings. Preventive medicine residency programs typically receive little funding through this model.¹¹ Even with the GME changes made in the Balanced Budget Act of 1997 (i.e., allowing Medicare GME payments to selected non-hospital based sites), most preventive medicine residency programs still are not able to receive reimbursement because these programs derive little or no revenue from direct patient care, a requirement to receive Medicare GME. The result is too few training slots to meet the real need.¹⁰ In fact, COGME has recommended that preventive medicine residency training be included in Medicare's GME financing system.¹²

As authorized in Title VII of the Public Health Service Act, HRSA has been a lifeline for General Preventive Medicine/Public Health (GPM/PH) training despite the fact that the amount of the appropriation for preventive medicine has been meager and declining. With reduced funding, the number of programs supported has declined and the number of residents supported within remaining programs reduced. As a result, some programs have closed and most are operating below their full capacity.⁷

HRSA funding (\$2.0 million in FY 2002) currently supports only about 34 physicians in 9 preventive medicine training programs, yet it represents the largest federal funding source for GPM/PH programs. Despite the growing need for preventive medicine expertise and critical contribution of HRSA's Title VII funding, the administration has zeroed out funding for most health professions education programs, including preventive medicine residency programs, in its FY 2004 budget. And, for the first time, it appears that Congress will not provide the necessary

funding to at least maintain the programs at or near their current level.

BOTTOM LINE

ACPM estimates that, annually, \$22.2 million is necessary to meet the need for training physicians in general preventive medicine and public health. This would provide funding for 400 GPM/PH residents, at a cost of \$55,500 per resident per year, compared to approximately 200 GPM/PH residents currently being trained.¹ Hence, the cost to train an additional 200 residents (an average of 4.5 additional residents per GPM/PH program), would be \$11.1 million, which would provide an adequate pool of specialists to begin to meet the growing demand for public health leadership.

CONCLUSION

In a world where threats range from AIDS to an epidemic of obesity, the need for an effective public health system is as urgent as it has ever been. The extent to which we are able to address the complex challenges of the 21st century depends, in large part, upon the quality and preparedness of our public health workforce. This workforce, in turn, is dependent upon the quality of public health education and training.¹³ Any efforts to strengthen the public health infrastructure, prevention research workforce, and disaster response capability must include measures to strengthen the existing training programs that help produce public health leaders.¹

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: __ (I-03)

Introduced by: American College of Preventive Medicine
American College of Physicians
American College of Surgeons
American Academy of Pediatrics
American Association of Public Health Physicians

Subject: Reauthorization and Strengthening of the 1994 Assault Weapons Ban

Referred to: Reference Committee __

Whereas, Our American Medical Association acknowledges that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health, as the weapons are one of the main causes of intentional and unintentional injuries and deaths (H-145.997); and

Whereas, Our AMA supports appropriate legislation that would restrict the sale and private ownership of large-clip, high-rate-of-fire, automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large-clip, high-rate-of-fire, automatic or semi-automatic weapon (H-145.993); and

Whereas, semi-automatic assault weapons are civilian versions of military weapons with features that allow users to rapidly kill large numbers of people; and

Whereas, one out of five law enforcement officers slain in the line of duty from 1998 through 2001 was killed with an assault weapon; and

Whereas, assault weapons have been used in many high profile mass shootings such as the one at Columbine High School in Littleton, Colorado and the Washington D.C. area sniper shootings.

Whereas, injuries from assault weapons have a particularly distressing effect on victims because increased firepower heightens the risk of multiple gunshot wounds and severe penetrating trauma, which can intensify devastation to the body; and

Whereas, the severity of wounds that result from assault weapons lead to high medical costs for treatment and recovery; and

Whereas, California significantly improved its state assault weapons ban in 1999 in response to gun industry efforts to evade a law passed in 1989, giving the federal government a successful model to follow; and

Whereas, the 1994 federal Assault Weapons Ban is scheduled to sunset on September 13, 2004; therefore be it

RESOLVED, that our AMA advocate for the renewal of the 1994 federal Assault Weapons Ban (**New HOD Policy**); and be it further

RESOLVED, that our AMA advocate for a strengthening of the ban to better regulate civilian transfer and possession of these weapons by:

- i) Clarifying the definition of an assault weapon to help prevent gun makers and sellers from evading the ban;

- ii) Banning conversion parts kits;
- iii) Regulating "grandfathered" assault weapons;
- iv) Enhancing the tracing of such weapons;
- v) Banning all high-capacity magazines, including imports; and
- vi) Prohibiting juvenile possession (**New HOD Policy**); and be it further

RESOLVED, that the AMA send a letter to the President, Attorney General, Surgeon General, and appropriate members of Congress indicating this strong support (**Directive to Take Action**).

Fiscal Note: No significant fiscal impact.

Existing AMA Policy

H-145.985 Ban on Handguns and Automatic Repeating Weapons

H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death

AMERICAN MEDICAL ASSOCIATION

Resolution __ (I-03)

Introduced by: American College of Preventive Medicine
American Association of Public Health Physicians

Subject: Environmental and Policy Interventions to Promote Physical Activity

Referred to: Reference Committee ____

Whereas, obesity and chronic diseases such as diabetes mellitus, hypertension, coronary artery disease, depression, and certain cancers have been linked to inadequate levels of physical activity;

Whereas, only 25% of US adults and 50% of US youth attain the recommended level of physical activity of 30 minutes a day on most days of the week, contributing to the epidemic of obesity and chronic diseases;

Whereas, the most common form of adult leisure time physical activity is walking and the number of walking trips taken by the average American declined by 21 percent between 1977 and 1995, and only 14 percent of all trips to school are made by biking or walking;

Whereas, *Healthy People 2010* has set a goal to increase the number of walking trips with a distance of less than one mile to 50 percent or more and to increase biking trips to school with a distance of less than 2 miles to 5 percent or more;

Whereas, the growing population of inactive individuals in industrialized countries is linked to the role of technology and the built environment in creating barriers to physical activity with the promotion of automobile use, more sedentary jobs, and decreased access to areas for recreational activity;

Whereas, the Task Force on Community Preventive Services has strongly recommended policy and environmental efforts to create or enhance access to places for physical activity;

Whereas, in September 2003 the *American Journal of Public Health* and *American Journal of Health Promotion* had special issues dedicated to the impact of the built environment on physical activity and other health outcomes;

Whereas, studies have shown that more leisure time physical activity is associated with higher accessibility to sidewalks, bicycle paths, and open areas to exercise;

Whereas, urban planning studies have shown that more walking and cycling for transportation is associated with neighborhoods of mixed land use, streets in a grid-like network, and high residential density;

Whereas, the *American Journal of Health Promotion 2003;18* reports that residents of sprawling counties were likely to walk less during leisure time, weigh more, and have a greater prevalence of hypertension than residents of compact counties;

Whereas, the *Journal of Epidemiology and Community Health* 2002;56 reports the presence of walkable green spaces positively influenced the longevity of urban senior citizens independent of socioeconomic status;

Whereas, AMA Policy H-440.917, “Increased Physical Activity for Most US Adults” calls “...for every adult to accumulate in the course of each day 30 or more minutes of physical activity of moderate intensity...”; and

Whereas, AMA Policy H-150.953, “Obesity as a Major Public Health Concern” urges “...federal support of research to determine: effective interventions to prevent obesity in children and adults;” therefore be it

RESOLVED, That the AMA work with other groups to prepare a set of advocacy materials (e.g., action alerts, sample letters to planning agencies and legislators, talking points, PowerPoint slides, etc.) and distribute these materials to state and local medical societies, health departments, voluntary health agencies, and other professional organizations to advocate for legislative, regulatory, and other policy changes, including but not limited to modifying zoning codes, promoting development of mixed-use, pedestrian and bicycle-friendly neighborhoods with adequate recreational facilities that would facilitate adults and children attaining recommended levels of physical activity (**Directive to Take Action**); and be it further

RESOLVED, That the AMA advocate at the federal level for funding to support ongoing research and interventions by governmental agencies, academic research centers, and state and local medical societies that evaluate and improve the role of the “built environment” (i.e., human-modified places such as homes, schools, workplaces, parks, industrial areas, farms, roads and highways) on physical activity and its effect on health outcomes, including the development and evaluation of federally-funded demonstration projects (**Directive to Take Action**); and be it further

RESOLVED, That the AMA encourage and support state medical associations to advocate for state-level funding to evaluate and improve the role of the “built environment” on physical activity (**Directive to Take Action**).

Fiscal Note: No Significant Fiscal Impact

Relevant AMA Policy

H-150.953 Obesity as a Major Public Health Program
H-440.917 Increased Physical Activity for Most US Adults
H-470.997 Exercise and Physical Fitness

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: __ (I-03)

Introduced by: American College of Preventive Medicine

Subject: Improving regional terrorism and disaster preparedness and response

Referred to: Reference Committee __

Whereas, Our American Medical Association acknowledges that the national security of the United States is dependent to a significant degree on the scientific, medical and public health community's actions (BOT Report 26-1-01); and

Whereas, the United States is relying on the entire healthcare system as much as or more than it has relied on the armed forces in the past to achieve and maintain security in the face of terrorism and disaster preparedness (BOT Report 26-1-01); and

Whereas, Our American Medical Association has been a strong advocate to improve the nation's medical preparedness in the event of a national emergency, including collaboration with the Department of Defense, implementation of the National Disaster Medical System, and various educational and collaborative meetings with national experts and commissions (BOT Report 26-1-01); and

Whereas, Our American Medical Association is uniquely positioned to bridge the gap between private sector medicine, academic institutions, state and local public health agencies, non-governmental organizations, and Federal agencies; and

Whereas, the General Accounting Office has found that regional planning for public health emergencies and bioterrorism is lacking between states (GAO-03-654T) and that hospital, public health and laboratory staff surge capacity will likely be exceeded in a large-scale disease outbreak (GAO-03-1058T); and

Whereas, local, state and Federal public health officials struggled with the degree of coordination required to provide a rapid and effective response to the anthrax attacks of 2001 (GAO-04-152); and

Whereas, the Federal role in preparedness, planning and emergency response to bioterrorism and public health emergencies needs to be clarified (*Biosecurity and Bioterrorism* 1(2):97-110, 2003); and

Whereas, proactive information dissemination to the professional healthcare community and to the public via the media is critical to maintain public confidence in an effective response (*Biosecurity and Bioterrorism* 1(2):97-110, 2003); therefore be it

RESOLVED, that our AMA call on the Department of Homeland Security and the Department of Health and Human Services to assure a multi-state coordinating capacity that would provide for more effective local, state, and interstate response to terrorist incidents, including planning, mass casualty care, and risk communication efforts (**New HOD Policy**); and be it further

RESOLVED, that our AMA call on the Department of Health and Human Services and the United States Public Health Service to expand the Medical Reserve Corps, a branch of the Citizen Corps, to include regional and nationwide organization of volunteer healthcare professionals to

provide additional personnel surge capacity in a national level medical response, including organizational requirements, educational and training needs, and credentialing and liability issues (**New HOD Policy**); and be it further

RESOLVED, that our AMA call on Federal and state agencies to develop a common credentialing standard with liability protection mechanisms to rapidly credential healthcare providers from other states to facilitate a regional or national level response (**New HOD Policy**); and be it further

RESOLVED, that the AMA send letters to the President, Secretary of Homeland Security, Secretary of Health and Human Services, Surgeon General, and appropriate members of Congress urging such action (**Directive to Take Action**).

Fiscal Note: No significant fiscal impact.

Existing AMA Policy

H-130.946 AMA Leadership in the Medical Response to Terrorism and Other Disasters

D-435.991 Bioterrorism – Protection from Liability

D-130.992 Medical Preparedness for Terrorism and Other Disasters

October 6, 2003

Articles
Parade Publications
711 Third Ave.
New York, NY 10017

Dear Editor:

This letter is in response to the September 14, 2003 article titled “Stay Healthy For a Lifetime” by Dr. Isadore Rosenfeld. The American College of Preventive Medicine (ACPM)—the professional society for physicians who specialize in disease prevention and health promotion—is pleased with Parade magazine’s prominent focus on prevention. However, we are very concerned that some of the article’s recommendations are not based on the scientific evidence of their effectiveness in promoting health and preventing disease. Additionally, the article omits some key recommendations. ACPM urges Parade magazine to publish a follow-up article that highlights the most important evidence-based preventive practices and would welcome an opportunity to work with Parade to prepare such an article.

ACPM recognizes that topic-specific guidelines and recommendations often differ and are endorsed by numerous sources, including professional medical societies, federal agencies, and independent task forces. However, it is essential that articles such as Dr. Rosenfeld’s, which can influence the health behaviors of millions of Americans, promote preventive practices that have been rigorously evaluated by credible organizations such as the U.S. Preventive Services Task Force (USPSTF). The USPSTF’s recommendations are widely considered the gold standard for evidence-based, effective clinical preventive practices.

Generally speaking, from a patient, provider, and public health perspective, screening and diagnostic tests are most valuable when targeted toward high-risk populations. Furthermore, the screening of groups not at high risk adds to the individual and societal burden of health care costs.

The following points address *some* of your specific recommendations:

- You recommend a cardiac stress test for men in their 50s. The USPSTF finds that there is insufficient evidence to recommend for or against screening middle-aged and older men for asymptomatic coronary artery disease, using exercise electrocardiography (ECG). Guidelines from the American College of Cardiology and from the American Heart Association also do not find evidence that exercise testing in asymptomatic men is useful or effective.

Letter to Parade Editor
October 6, 2003

Page 2

- You recommend that women in their 50s receive an annual bone-density test for osteoporosis. The USPSTF and the National Osteoporosis Foundation guidelines (developed in collaboration with the American Academy of Orthopaedic Surgeons, American College of Obstetricians and Gynecologists, American Geriatrics Society, American College of Rheumatology, American Medical Association and other medical societies) recommend routine bone density testing in women aged 65 and older. Screening women younger than 65 years of age is recommended based on the presence of risk factors.
- You recommend pneumococcal vaccine for all healthy adults 65 and over. While this is an important target group, leading organizations *also* recommend vaccination for adults younger than age 65 years with medical or living conditions that put them at high risk for invasive pneumococcal disease. These organizations include the Advisory Committee on Immunization Practices (ACIP), American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians (ACP), and USPSTF.

ACPM, which develops and advocates for evidence-based prevention policy and recommendations, strongly urges Parade magazine to use and cite evidence-based guidelines for future health-related articles as well as provide links to websites such as the one for the Agency for Healthcare Research and Quality (www.ahrq.gov) that make these guidelines available for both providers and the general public.

Sincerely,

Robert G. Harmon, MD, MPH, FACPM
President
American College of Preventive Medicine



Leadership in the Science, Policy and Practice of Preventive Medicine

NEWS

**For Immediate Release Contact: Michael Barry (202-466-2044,
July 18, 2003 mab@acpm.org)**

ACPM ISSUES RECOMMENDATIONS TO ADDRESS SEVERE SHORTAGE OF PREVENTIVE MEDICINE PHYSICIANS

Washington, DC – The American College of Preventive Medicine issued a series of recommendations today to increase the number of physicians qualified to assume leadership positions in state and local public health agencies. An article in the latest issue of *Health Affairs* (“A Prescription for Change: The Need For Qualified Physician Leadership in Public Health”) calls attention to this critical shortage of public health physicians.

In the article, the author, Dr. Laura Kahn, highlights data from the American Medical Association showing that over the past 30 years the number of public health physicians has declined from 2.3 percent to 0.8 percent of the total physician workforce; and data from the National Association of County and City Health Officials showing that only 23 percent of local health agencies are directed by physicians. She illustrates how health department leaders who are not physicians may have difficulty handling serious outbreaks and other medical emergencies. According to Dr. Kahn, the critical skills needed to manage today’s health departments in an era of emerging threats (both natural and intended) include epidemiology and the ability to diagnose illness and prescribe medical interventions. Dr. Kahn recognizes that these skills are taught in preventive medicine residency programs, yet financial support for such programs is weak.

To increase the supply of physicians board-certified in preventive medicine, i.e., the medical specialty that trains physicians in public health, the ACPM recommended the following:

- ◆ Congress should resist the Bush administration’s efforts to eliminate funding for public health and preventive medicine training in Fiscal Year 2004, and should provide funding at least equal to the \$10.5

million provided in the current health professions training program of the Health Resources and Services Administration.

- ◆ Congress and the Bush administration should amend the Medicare Graduate Medical Education program to make preventive medicine residency programs eligible to receive Medicare GME support.
- ◆ Medical schools should expand the amount of preventive medicine training given to medical students.
- ◆ Funding to states and localities from the Centers for Disease Control and Prevention should provide financial incentives to hire preventive medicine-trained physicians in densely populated jurisdictions.

Preventive medicine is one of the 24 medical specialties approved by the American Board of Medical Specialties, the nationally recognized body that approves medical specialties.

According to ACPM President Robert Harmon, MD, “With more attention and resources being directed to emergency preparedness at the state and local levels, the dearth of preventive medicine physicians is becoming more apparent and more acute. Preventive medicine, as a certified medical specialty that produces physicians trained to meet the public health challenges facing communities, can help address this serious workforce shortage, but policy makers must allocate more resources to make it happen.”

The American College of Preventive Medicine is the national professional society that represents physicians trained in preventive medicine. Board-certified preventive medicine physicians are uniquely trained in both clinical medicine and public health, which includes such skills as epidemiology, biostatistics, and health administration. ACPM's members are engaged in preventive medicine practice, teaching and research. ACPM advocates for the specialty of preventive medicine and for national policies that promote health and prevent disease. ACPM maintains an active presence on Capitol Hill and among the many federal agencies and non-governmental organizations that shape national health policy.

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October 8, 2003

Public Health Leadership Society
c/o V. James Guillory, DO, MPH, FACPM
Associate Dean, Division of Research
Associate Professor and Chair, Preventive Medicine
University of Health Sciences
1750 Independence Ave.
Kansas City, MO 64106

Dear Dr. Guillory:

The American College of Preventive Medicine (ACPM) is pleased to inform you that it endorses the Principles of the Ethical Practice of Public Health (hereafter *Code of Ethics*). ACPM applauds the Public Health Leadership Society in taking on the much-needed task of explicitly defining ethical practice in public health. Similar to organized medicine, which has defined and refined many times over ethical standards of practice for physicians, the public health community has tackled the important task of defining how to appropriately exercise its power to ensure health while at the same time avoid the potential abuses of power.

While ACPM supports the Code of Ethics as written, several of our members during the process of reviewing the document offered a number of substantive comments and suggestions for improving the code, recognizing that the code is a “living” document that will be transformed over the coming years to better meet the needs of the public health workforce and communities it serves. I have consolidated the comments received into one document and have attached them for your consideration. Our hope is that PHLS will take these comments into consideration during the next iteration of the code.

Thank you again for providing ACPM with the opportunity to review the Code of Ethics, and we look forward to working with PHLS in the promotion of the ethical practice of public health. Please call me at 202-466-2044 (x106) if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael A. Barry". The signature is fluid and cursive, with a long, sweeping underline that extends to the right.

Michael A. Barry
Deputy Director, ACPM

Principles of the Ethical Practice of Public Health

1. Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.
2. Public health should achieve community health in a way that respects the rights of individuals in the community.
3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.
4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.
5. Public health should seek the information needed to implement effective policies and programs that protect and promote health.
6. Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community's consent for their implementation.
7. Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.
8. Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.
9. Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.
10. Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.
11. Public health institutions should ensure the professional competence of their employees.
12. Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.