Why We Don’t Spend Enough on Public Health

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The field of public health has long been the poor relation of medicine. Medicine — in which most resources are used to help cure individual patients after they have become sick or injured or to help manage already-existing chronic conditions — is flashy, its master practitioners and innovators lionized, and its accomplishments widely celebrated. In contrast, public health — in which most resources are focused on trying to keep something bad from happening in the first place — is seemingly mundane, its efforts and prime movers often all but invisible.

Medicine is primarily a private good — the patient receives the main benefit of any care provided. Payments usually come from the individual patient and, in the developed world, from private and governmental insurance. Public health, on the other hand, provides public goods — such as a good sewer system — and relies almost exclusively on government funding. It is generally acknowledged that public health is systematically underfunded and that shifting resources at the margin would be reaped on someone else’s watch. They therefore put great effort into putting out today’s fires and relatively little into preventing tomorrow’s conflagrations.

Second, the beneficiaries of public health measures are generally unknown. Whereas medicine typically deals with identifiable people (patients), public health typically deals with statistical “lives.” The medical care you receive is directed at helping you. Public health interventions, on the other hand, are aimed at improving road safety, preventing mad cow disease, or limiting climate change that will potentially yield benefits in the future, many politicians correctly understand that their administrations will bear the costs, but the benefits will be reaped on someone else’s watch. They therefore put great effort into putting out today’s fires and relatively little into preventing tomorrow’s conflagrations.

Third, in public health, the benefactors, too, are often unknown. Although public health efforts are recognized by some as having played a more important role than curative care in improving our country’s health over the past century, the American public, through no fault of its own, has almost no idea what public health professionals and programs do. Public health has little news value — saving statistical lives doesn’t make for good human-interest stories or photo ops. Public health also has few well-known scientists or leaders. Whereas many people have heard of such medical giants as Michael DeBakey and Christiaan Barnard, I would venture to guess that few...
know about their contemporary, Maurice Hilleman, a researcher who developed more than 30 vaccines (including those for measles, mumps, and chickenpox) and who is credited with saving more lives than any other 20th-century scientist.

When people benefit from public health measures, they often don’t recognize that they have been helped. In the United States today, it is easy for people to take it for granted when, on any particular day, they don’t get sick at work (because of air-quality improvements), aren’t poisoned (because the food is safe), or don’t get run over (because the walkway has been separated from the road). In the few cases in which people do recognize that they’ve been helped by preventive measures, they rarely know who provided the benefit. In contrast, the help provided by curative physicians is more easily identified. So whereas grateful patients, in turn, provide much financial support for hospitals, there is generally no grateful public providing substantial support for public health initiatives.

Fourth, some public health efforts encounter not just disinterest but out-and-out opposition. Such initiatives often require societal change, which runs counter to the well-documented human characteristics of “status quo bias” and “tradition-bound resistance.” Even the most successful public health initiatives, such as the “great sanitary awakening” of the 19th century, which dramatically reduced the spread of tuberculosis, were met with fierce opposition.4

Societal change is hard, and it is especially difficult when it imposes costs on powerful special interests. In the past half-century, those opposing beneficial public health measures have included some of our most potent political lobbies, representing the interests of the alcohol, tobacco, firearm, automobile, coal, and oil industries. For instance, Americans who die before 40 years of age are more likely to be killed by an injury than a disease. In the early 1990s, firearms were the second-leading cause of injury-related death in the United States, killing 100 civilians per day. The Centers for Disease Control and Prevention (CDC) began spending a disproportionately small amount of money on this enormous issue — $2.6 million (about a penny per person) on data collection and research each year. One CDC-funded study of violent deaths in the home showed that the presence of a gun in the household was a risk factor for such deaths.5 But congressional delegates on the CDC appropriations committee, bowing to the wishes of an outraged gun lobby, tried to shut down firearm-related activities at the CDC. Although initially unsuccessful, their attempt had such a chilling effect that the CDC has effectively stopped funding research on this major public health problem.

In contrast, increases in resources for medical care are usually promoted rather than opposed by large special interests, from pharmaceutical and medical insurance companies to physicians, nursing homes, and hospitals.

Epidemiologists are taught to recognize and address the problems of systematic error. Hospitals are learning to detect and prevent systematic errors in providing medications and other practices. Similarly, our country needs to understand and try to correct systematic policy errors — including the tendency to underinvest in public health.

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**Syphilis and Social Upheaval in China**

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Syphilis, a sexually transmitted infection (STI) that was nearly eliminated from China 50 years ago,1 is now the most commonly reported communicable disease in Shanghai, China’s largest city.2 No other country has seen such a precipitous increase in reported syphilis cases in the penicillin era.