

Public-Private Partnerships in Chronic Disease Prevention Part 1

[Announcer] This podcast is presented by the Centers for Disease Control and Prevention. CDC – safer, healthier people.

[Elizabeth Majestic] My name is Elizabeth Majestic and I'm the Associate Director for Program Development for the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention. And I'm serving as the guest editor for this special theme issue for *Preventing Chronic Disease*, which is focused on creating partnerships with the for-profit sector.

With me today is Gene Matthews. Gene is the former general counsel for CDC, where he spent 25 years working on issues such as AIDS, Monkeypox, SARS, occupational safety and health, as well as chronic disease prevention and health promotion. Currently, he is a senior fellow at the Gillings School of Public Health at the University of North Carolina. Welcome Gene.

[Gene Matthews] Thank you for having me.

[Elizabeth Majestic] Gene, to set some context for this interview, I thought it would be helpful if you would start by providing some of the history for public health in terms of its relationships with the private sector.

[Gene Matthews] Well, it's an interesting question. I was a history major before I went to law school. And you really have to look back historically...go back, say at least a hundred years, to a time when public health was much more engaged and grounded with the private sector and I think a lot of that had to do with the need to quickly implement public health community-wide control measures like a quarantine for smallpox or closing a facility due to spread of polio and so if you look, say, in the 1890s, a young lawyer on Long Island named Teddy Roosevelt was very instrumental in helping his community implement a polio quarantine in his hometown on Long Island. Or early 1900s, again, a lawyer in Chicago started a group that met regularly and rotated its groups. It was interested in civic improvement activities. It became known as the Rotary Club and the first two things that the Rotary Club did...number one was to buy a horse for the community doctor to move around more effectively in and the second was to build the first public restroom in the city of Chicago.

So there's a rich history if you go back, either in the legal profession or the private sector, in general, of public health being much more engaged in the political environment. Political with a small "p" in the community environment. And I think that changed somewhere in the 1950s and early in 1960s in this country. One reason was, I think, with the advent of the Salk polio vaccine in 1955, there was no longer...that culminated the final piece in the great vaccination developments, going all the way back to Jenner and smallpox and so forth. And that, together with the antibiotic bubble that created from World War II, was a lot more ways of treating

disease so we no longer needed to close swimming pools because of polio. When I was a kid that happened. Or to worry about smallpox quarantines and things like that.

So public health lost in many sectors its grounding in needing to be immediately responsive and immediately effective in quickly changing community policy...implementing control measures. You've got to have the consent of the government... of the governed in order for the government to do these kinds of things and that, coupled with the Great Society programs that developed in the 60s, public health became much more perceiving itself as a service delivery arm of the government rather than...in our constitution it's a police power function.

So... and public health then drew inward into itself. We look at ourselves and are not really focused on what's going on as much in this external world of politics at the federal, state, or local level. We took a position of "We do good work, we do good science, here's the science behind what we do, kindly give us money and leave us alone." I think we became more and more isolated from that. We almost became, not only with the political system, but with dealing with the private sector. We tended to view business as the enemy and not to be trusted and I think the business community...the private sector... began to lose that grounding on what public health really does to stop a polio outbreak or a smallpox outbreak.

[Elizabeth Majestic] And then Gene, as we have evolved in our history and began to get infectious diseases under control, then we start to see the emergence of other issues that public health cannot...

[Gene Matthews] Yeah, chronic disease prevention, all of that...and during my career we built a lot of cases of why prevention is cost effective but we could never compete. This is what Bill Fagey said in the mid 80s. That we were never able to compete effectively with the next technology for patient care. Be it an MRI or whatever the standard of care was. That was the entitlement driver for health care in this country and we always were playing catchup, trying to say "Yes, but if you spend 10 percent of that money on prevention you won't have that number of cases of diabetes or asthma or whatever to begin with." And it's a very difficult sale to make, particularly with public health becoming, I think, less and less skilled in the tools needed to make that case at the community level, at the state level, and at the federal level with both the non-profit sector and for-profit sector.

[Elizabeth Majestic] I've heard you talk about other areas of public health, like occupational health and safety, as an example. What lessons can we learn from that area that you think might be applicable to the field of chronic disease prevention and health promotion?

[Gene Matthews] It's very interesting because, again, for not all of my career, but probably beginning in 1983, I became the chief lawyer for the National Institute for Occupational Safety and Health, NIOSH, and that became part of CDC at that time. And NIOSH, in some respects, was certainly the most adversarial to the business community. That was their job. They came from that culture. But even going all the way back to the regulations before my time that implemented the Mine Act and the OSHA Act that set up NIOSH, they developed this transparent, inclusive concept of the tripartite meetings. When you go in to do a health hazard evaluation at a plant, part of the NIOSH culture is we sat down with the tripartite...the

government, the employer, and the representatives of the employees, and lay all the cards out on the table. Here's what we want to do, here's why we want to do it, here's how do we go about getting it done. So that culture, I think, gave NIOSH a bit more savvy into how to be discerning in its partnership activities.

[Elizabeth Majestic] And what do you think the keys were to the process that they undertook that were so important that moved that forward?

[Gene Matthews] The keys are shown in a more recent example of the NORA, the National Occupational Research Agenda, that NIOSH did, by again, it was done transparently, it was done inclusively, and it was done with some integrity. I mean, the leadership of NIOSH that did that were no fools in knowing what, if there's no boundaries set on this, then, you know, it's the job of industry to get what they want, but there was common ground that was identified in the 1990s of inability to do all of the research necessary in occupational health and the industry and the labor representatives were all interested in that common ground. We've got to divide this up, do it in a way that the ultimate product has integrity and validity and is not looked at as well this is another industry study to justify...or this is another union study to justify their particular political agenda and I think it is a good example of how you apply those principles of integrity and leadership and transparency to do things which otherwise might be a little bit difficult or squeamish for do-gooders like myself in public health to do.

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